University of Alberta

Buddhism, Biomedicine, and Happiness in the Healing Traditions of Contemporary Bhutan

by

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A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Master of Arts

Department of Anthropology

Edmonton, Alberta
Spring 2008

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395 Wellington Street
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Direction du
Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-45727-6
Our file Notre référence
ISBN: 978-0-494-45727-6

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ABSTRACT

The purpose of this thesis is twofold: the first, to present a preliminary ethnography exploring medical pluralism in Bhutan, a topic previously unexamined in the country, and the second is to produce an ethnography of everyday life in one of the least known nations in the world. This study contributes to an understanding of concepts of health and available health care options in this Buddhist country. Pluralism characterizes many aspects of Bhutanese society and culture, including the health care system, which offers equal access to biomedicine and Tibetan medicine free of charge. Taking a highly contextual approach to the study of health care in contemporary Bhutan, this thesis examines medical pluralism within a larger socio-cultural and political framework, including Tibetan Buddhism, rapid culture change, a new and emerging class system, and a development policy referred to as Gross National Happiness.

ACKNOWLEDGEMENTS

I would like to thank the CBS and my counterpart Karma for all their hard work in facilitating this research project, and I would like to thank Dr. Chencho Dorji for his help, encouragement, and guidance before, during, and after the completion of my fieldwork in Bhutan. To my Tibetan friends in Bhutan, I would like to say thank you for your good company and for introducing me to Special Courier.

Funding for this project was provided by The Mactaggart Award. I would like to thank Sandy Mactaggart for his generous financial support, allowing me to conduct fieldwork that otherwise would have been impossible. Two of my undergraduate professors, Andrew Lyons and Mathias Guenther, also deserve a big thank you for encouraging me to pursue graduate work in anthropology. And thank you to my current supervisor Christopher Fletcher for supporting a project that initially seemed like an amazingly impossible dream.

Finally I want to thank my family, my mother Marilyn Perdue, my sister Livia Goodbrand, and my aunt Wendy Perdue for their unconditional support in everything I want to do. A big thank you to my Grandmother, she was always my best editor.

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Chapter 1

INTRODUCTION

My journey to Bhutan began a year before I actually arrived in the country. People have often asked me at home and in Bhutan how I learned about the country and what brought me to it as a place to conduct ethnographic research. The first time I heard about Bhutan was in 2002 while teaching English in Japan. I had been watching the news and saw a story about Bhutan's recent acquisition of television (the first television broadcast took place in 1999). More than anything, I was intrigued by the images coming from a place high in the Himalayan Mountains, a place I had never heard of before.

In 2005 I entered my Master's program and decided I wanted to do my dissertation on health care in Bhutan. I applied for funding and for permission to enter the country that same year, but it was almost a full year before I received confirmation that my visa application was successful. It was another two months before I would touch down at the airport in Paro, Bhutan. In the meantime I was fortunate to volunteer at a conference in Antigonish, Nova Scotia entitled, "Rethinking Development: Local Pathways to Global Wellbeing", which was also the Second International Conference On Gross National Happiness. The first conference took place in Thimphu, Bhutan in February of 2004. Following on the first conference, the second highlighted Bhutan's development strategy Gross National Happiness (GNH). This dissertation is about the healing traditions of contemporary Bhutan and the unique context in which health care takes place in this ancient Buddhist kingdom.

In the context of the current shift toward a more decentralized form of government in Bhutan, Karma Ura describes the country's historical background, and highlights pluralism as an attribute inherent to society and culture in that country (Ura 2004). Ura writes, "[in] the past Bhutan existed through a diversity of forms of life found in all kinds of communal variations, and that decentralization today can sustain and revive that heterogeneity" (2004, 2). The fourth King has declared a commitment to decentralization and to democracy through the devolution of his own powers and a return to community centered, local development initiatives. Ura suggests that decentralization is an effort to return to a time "when the country stood-united in the midst of pluralism and when there was far less common history, common language and common culture than today" (2004, 2). Pluralism is a characteristic of Bhutan's past, but it is also part of an historical continuity that is present on many levels in Bhutanese society today. As a concept pluralism may be used loosely to define a variety of social, religious and linguistic elements. In the past, Ura asserts, pluralism was present in many areas of life, including law, civil service, economic production, associational life, language, and religion (Ura 2004, 2). According to Ura, social and structural pluralism in Bhutan is a product of the localized and highly autonomous nature of Bhutanese communities, and an historical tendency toward decentralized rather than centralized authority (Ura 2004). As Ura demonstrates, the current shift toward decentralization is part of a larger historical reality (Ura 2004). Traditionally, the act of governing took place at the community and village level, resulting in a plurality of legal, economic, and associational rights and obligations. For instance, a 1995 revision of the rules and procedures, or *chathrim,* for the election of National Assembly members continued to allow a variety of procedures unique to different localities (Hutt 2003, 131). Language is another area where pluralism may be used as a descriptive framework. Although Dzongkha was declared the national language in 1961, Bhutan is, in fact, linguistically heterogeneous. An exhaustive account of the country's history by Michael Aris (1979) reveals a plurality of dialects, many of which are mutually unintelligible. But the most "vivid form of pluralism", according to Ura (2004, 8), is the diversification of Buddhist religious sects. Like Tibet, which prior to the Chinese takeover was characterized as a non-centralized state (Samuel 1993), and with which it shares a common history and culture, Buddhism in Bhutan is defined by its pluralism and flexibility. Bhutan's varied and diverse religion and culture encompasses the influences of Buddhist masters of a number of different schools, including but not limited to *Sakya, Bon, Dzogchen, Peling, Dorling, Neyryingpa, Lhapa, Drigung, Shingtawa, Katerpa, Kardrupa, Gaylugpa,* and *Chagzampa* (Ura 2004, 8). Broadly speaking then, pluralism characterizes many aspects of Bhutanese social, political, cultural, and as I will demonstrate, medical and health-related spheres of experience. Scholars, both Western and Bhutanese have written about the country's language, political system, and religion, but none have documented the country's health care system; thus there is a significant gap in the ethnography of health and healing in Bhutan, which this paper will begin to fill. This thesis will also show the high degree of interconnection between social, religious, and medical acts in Bhutan's Buddhist culture.

Pluralism within the medical system can be seen at the institutional level, in the diverse origins of illness experiences within the Tibetan medical framework, and in the multiplicity of health care options available to health seekers in times of illness. Health seekers in Bhutan access multiple health care options, which are often used in a complementary way. As one individual told me, "we do everything side-by-side". In Bhutan, Tibetan medicine is one half of a free government supported medical system, which includes biomedicine; both are under the direction of the Ministry of Health.

Along with pluralism, health care in Bhutan has another important feature, which makes the study of health in that country challenging for a Western-trained anthropologist. From a Western perspective, health and health care decisions are generally thought of as highly individual experiences. Western religion, philosophy, and psychology have reified the individual and emphasized our separateness from one another. Existentially individuals are grounded in their own autonomous experience of life. Examining health care in a Buddhist culture, as I have done in Bhutan, requires the anthropologist to understand and enter into a philosophical, religious, and psychological reality that values interconnectedness. Buddhism emphasizes interdependence, interrelatedness, and the individual as a "relational entity" (Ura 2004, 29). Individual identities are formed in relation to the community, within a religious framework that emphasizes compassion and empathy for all beings. Like pluralism, interconnectedness is present on every level of Buddhist society in Bhutan. It is the ground on which individuals live out their lives. In Bhutan, the medical sphere of life is deeply connected to other spheres of experience, an aspect of health care in that country which I emphasize throughout this thesis.

Buddhism in Bhutan is a colourful and complex form of Mahayana Buddhism that originated in Tibet, and can be referred to as Tibetan or Tantric Buddhism. It is a religious complex where spiritual practice and concepts of health are deeply connected. Returning to the theme of pluralism in Bhutan, Tantric Buddhism incorporates a rich variety of Buddhist and pre-Buddhist elements, including spirits, deities, demons, and the Buddhist doctrine of karma and rebirth. Out of Tibetan Buddhism, emerged a scientific tradition that envisions mind and body as a "genuine unity" (Samuel 1989, 202). Tibetan Buddhism and Tibetan medical theory are the foundation of what Craig Janes has called a "complex subjectivity" that "integrates the mind-body with the social and natural universes in a host of ways" (1999, 394). Health seekers can access a plurality of Tantric clerics and Tibetan medical practitioners with abilities that range from strictly ceremonial to what we in the West might call magical, all of whom are involved in the work of healing. After living in Bhutan for almost ten years Jamie Zeppa describes Buddhism in Bhutan as "curiously elastic" because it seems to incorporate and embrace everything, from the esoteric to the pragmatic (2006, 20). Buddhism in Bhutan is an intriguing mixture of elements that are colourful, opulent, and other-worldly but, as Zeppa describes, incredibly practical and completely of-this-world (2006, 20). For those who have never spent time in a Tibetan Buddhist culture it is difficult to describe how Buddhism permeates every aspect of life. Even for an outsider, it is a complete sensory experience. As a visitor you begin to see, hear, smell and embody Buddhism and its practices. For example, it is difficult to walk anywhere in Thimphu, the capital city, without using the yellow rooftop of a nearby temple or Lhakhang as a reference point. The cacophony of sound made by trumpets, cymbals, and drums accompanying Buddhist ritual can be heard day and night. Incense and burning juniper become familiar smells, and according to custom you learn to walk around chortens (shrines) in a circle from left to right, a rule that even cars obey. When visiting temples, you see indescribable paintings, statues, and ornaments that through their sheer size, colour, and grandeur communicate to you a sense of immediacy, a sense of 'now-ness' that is so much a part of Buddhist philosophy in general. These things are the material and sensory expressions of a particular social milieu, but one that is immediately engaging to those not familiar with Tibetan Buddhist culture.

Buddhism is a palpable and highly visible component of culture and health care in Bhutan. But there are other, often conflicting, forces at work in the country today that are equally as influential. Evidence of modernization is everywhere, and for the first time, Bhutan is grappling with many of the problems that accompany rapid change and development. Gangs, drug use, youth unemployment, and a free marked economy are relatively new additions to life in this Buddhist kingdom. The country is an intricate and complex mixture of new and old social forms, and what has emerged is characteristic, as Arthur Kleinman points out, of societies in the throes of change:

> in such modernizing societies, one finds social realities that are a strange amalgam of modern and traditional beliefs, values, and institutions, held together in varying patterns of assimilation, complementarity, conflict, and contradiction. (1980, 37)

As with other developing societies, changes that are affecting other cultural systems in Bhutan have profound implications for the health care system as well (Kleinman 1980, 37). As Kleinman suggests, considering that modern medical ideas and practices represent "the tip of the wedge" of new ideas and technology introduced in the modernization process, it is not surprising that health care systems provide some of the "sharpest reflections" of the tension and problems that arise as a result of large-scale social development and change (1980, 37). Thus, health care in Bhutan is reflective of changes occurring in the country on a much larger scale. There are indications that many of the tensions Kleinman refers to may emerge, not only as a result of new technologies and health philosophies, but also as a result of shifting social-structural variables, like class, a new and emerging national consciousness, and divisions along ethnic lines. Members of the old elite have generally had access to higher education outside the country, and to positions of power within the government. I believe a pattern is emerging whereby upper-middle class individuals pay for health care services outside the country, and as user fees are introduced they will be able to buy 'better' health care inside Bhutan as well. The Bhutanese government has created a national culture, including a national dress code and language, based on the traditions of the dominant Drukpa Buddhist sect, this despite a culturally and linguistically diverse population. It has also created a unique development policy it calls Gross National Happiness (GNH). GNH is a concept that was articulated by the fourth King, Jigme Singye Wangchuck in 1971 when he made the now famous statement, “Gross National Happiness is more important than Gross National Product”. GNH has become part of a carefully crafted development plan for the country. It is a multidimensional concept that encompasses a number of different factors or ‘pillars’. The government has outlined four pillars or development goals, which it hopes will help to create the conditions under which people can pursue happiness. They are: sustainable and equitable economic development, conservation of the environment, the preservation and promotion of culture, and good governance. While outwardly promoting a national identity based on the well-being and happiness of its population, Bhutan struggles with many of the social problems that are present in countries around the world. The country reportedly expelled some 80,000 people of Nepali origin in the early 1990s for allegedly refusing to comply with the policy promoting national traditional culture. This situation has yet to be resolved.

The modernization process has altered local realities and identities, a process that will continue to bring change to villages and communities throughout the country. While in rural Bhutan, I spoke to a ninety-four year old woman who gave birth to thirteen children at home. In those days, she told me, there were no hospitals and no roads in or out of her village. Today, there is a health unit in the village, a facility that provides traditional medicine and biomedicine, as well as roads that allow for transportation to a district hospital. Where once the household and the community were the locus of one's identity and sense of place (Ura 2004, 8), Bhutan is now part of a larger global community. These changes have dramatically altered people's experience of health and the type of health care people can access.

Health care is an area where Bhutan wants to build self-reliance and sustainability. Like other developing countries Bhutan is concerned with the health of its people and its primary objective has been to prevent and reduce morbidity and mortality rates among the population. Maternal health, infant mortality, malaria, dysentery, leprosy, and the recent arrival of HIV/AIDS into the country are just some of the concerns before the Ministry of Health that are being targeted by proactive health care strategies. Other health care initiatives include a complete ban on tobacco and cigarettes in December 2004.

An examination of Bhutan's medical system is important for several reasons. First, there is a scarcity of ethnography on Bhutan in general and none on the health care system in particular, although as Susan Neill asserts this may not be for lack of interest (1997, 46). Neill (1997) has written an article about Bhutan's careful construction of its national identity, which suggests that although many researchers are interested in Bhutan, they are often denied access to fieldwork because of the government's discomfort with criticism. Historically speaking, Bhutan has always taken a cautious approach to the dissemination of information about the country. They have also taken great care in shaping the country's public persona. For this reason, I was very fortunate to be granted a visa, which allowed me to conduct four months of anthropological fieldwork.

Secondly, although there is a growing interest in Tibetan medicine, both for its medicinal and spiritual aspects, it is not well represented in the anthropological literature. Tibetan medicine is a significant and largely unaltered aspect of medicine and culture in Bhutan, and as such, I have concentrated a large portion of this research to an examination of the philosophy and methodology of this ancient medical tradition. A survey of anthropological literature on traditional health care systems reveals a wide array of articles on Ayurveda and Traditional Chinese medicine, and an unfortunate dearth of data on Tibetan medicine. Recent ethnographic articles on Tibetan medicine include those by Craig Janes (1999) and Vincanne Adams (2001). They have made significant contributions to the study of Tibetan medicine, a small but growing body of work.

The research conducted for this paper represents an initial exploration, a reconnaissance mission if you will, to document and describe the various components of Bhutan's health care system. This will involve describing the Tibetan medical system, including treatment options and the pharmaceutical unit where medicinal compounds are processed and manufactured. I will also describe how the Tibetan medical system and the biomedical system interact. Using examples, I will describe when and for what types of ailments people use these two systems. Conducting research in Bhutan revealed some surprising data on the use of religious healers like lamas and their relationship to the biomedical system. I describe the biomedical sector and demonstrate that biomedicine has been absorbed into, and altered by the cultural context itself, a process that Arthur Kleinman refers to as "indigenization" (Kleinman 1980, 55). My initial findings hint at some interesting modifications to the biomedical setting and practice. The data led to many questions and provided an intriguing first glimpse into how the biomedical approach to health has been integrated into a country with a strong medical tradition of its own. I will describe points of interest as I observed them at the largest hospital in Bhutan, Jigme Dorji Wangchuck National Referral Hospital, and illustrate how and under what circumstances biomedicine is practiced in Bhutan at the busiest hospital in the country. This research will show the complexities, pluralities, and ambiguities of this unique and rapidly changing country. The material in this thesis ranges widely and covers a number of areas of inquiry, each of which could constitute a separate research paper. I have chosen a more holistic format to present life and health in Bhutan as I experienced it, a rich and integrated whole.

Method

Given the preliminary nature of this fieldwork and some restrictions placed on the scope of my research by the Ministry of Health, I kept my methodology simple. I relied on participant observation in combination with informal interviews and a very small number of formal interviews. Formal interviews were often difficult because of language, especially with the elderly and with rural Bhutanese, many of whom did not speak English. Many of my meetings and encounters with health system users and with health care professionals were informal and loosely structured, and there were some cases where I judged that using a tape recorder while conducting an interview was not appropriate. I found that exposure to and participation in daily life in Bhutan was an invaluable way of gaining insight into the lives of Bhutanese people. There were many instances in rural Bhutan where I participated in activities without the benefit of understanding the language; these were often the most enlightening.

Although I was working with a 'counterpart' who acted as my translator, much of my data has been filtered, once through my counterpart and a second time through my interpretation of his translation. I have done my best to impart what was translated and described to me by my counterpart as clearly and precisely as possible. I carried a notebook at all times and took copious notes during and after interviews and encounters. In addition to my field notes, I kept a journal in which I recorded thoughts and observations.

Conducting research in Bhutan required that I become knowledgeable in a number of areas, most importantly Tibetan Buddhism and Tibetan medicine. These are extremely complex and nuanced traditions and practices. Therefore, I have drawn from the work of researchers in the field of Tibetan Buddhism to help describe some of the more complex philosophical aspects of Buddhist culture and religion. Sources on Tibetan medicine have also been invaluable. Moreover, I have used publications from the Ministry of Health in Bhutan to supplement my own findings on the health care system.

Fieldwork

Fieldwork was conducted in Bhutan over a four-month period. I spent most of my time in the capital city, Thimphu, and one week living with a family in a village called Ura, in Central Bhutan. Thimphu is located in Western Bhutan and is the largest city in the country with a population of around 50,000. In terms of size, it is not really accurate to say that Thimphu is a city; it is more like a small town. It is sprawled out over a large area in a valley surrounded by pine-covered mountains. Thimphu is a mixture of traditional Bhutanese culture and Western cultural elements. Amidst traditional Bhutanese architecture there are a growing number of Internet cafés. There is also a small assortment of Western-style coffee shops, which I found have the strange effect of removing you from the reality of being in Bhutan; at times I felt as though I could have been anywhere in the world. For its small size, Thimphu also has a wide array of restaurant choices, including really good pizza, pasta, Chinese, Thai, and Indian food. There are also large packs of semi-wild dogs. For Buddhists, animals can be reborn into the human realm and vice versa; any suggestion that they be gathered up and euthanized has been soundly quashed.

The city is growing quickly as more people move from rural areas to urban centers where there is better access to employment and social services. As the capital city, Thimphu is the hub of political and monastic activity. It is also the center of the tourism industry and is where most tourist groups stay before departing for Eastern Bhutan. As the capital city, it is symbolically and geographically the centre of Drukpa Buddhist culture, which is located primarily in the western part of the country. Although there are several Tibetan Buddhist sects in Bhutan, the Drukpa sect is the dominant school; moreover, this form of Buddhism is also the state religion in Bhutan.

My second field site was Ura, located just right of center in a dzongkhag (district) of Bhutan known as Bumthang. Although I spent a relatively short time in Ura, my experiences and observations were of a caliber and richness that necessitated inclusion. It is believed that Ura was settled by people from Tibet and therefore, has strong historical, cultural and mythological ties to that country. I have chosen to present data collected in Ura, as a separate section because I believe the information is more valuable when examined within the context in which it was collected. The choice to present the data from Ura and Thimphu separately is meant to be the beginning of what could be a much larger comparative study covering health care in urban and rural areas. As Bhutan continues to change and develop, it will be interesting to see how health care changes to meet the needs of urban and rural populations. The government is already concerned about the depopulation of rural villages, a trend that may impact the type and concentration of health care available in places like Ura. I have also chosen to present a small amount of data from Shingkar, a village about an hour from Ura, because it also documents rural life and health care. I have presented the experiences of one individual in particular whose narrative yields some surprising insights into how individuals negotiate the health care system in times of sickness. The data on Shingkar and Ura are both presented at the end of the paper.

The Center for Bhutan Studies and My Counterpart

My time in Bhutan was facilitated by the Center for Bhutan Studies (CBS), an autonomous research institute whose mandate is to promote and facilitate research on Bhutan. It hosts seminars and conferences within the country and produces its own journal. The CBS has an in-house group of full-time Bhutanese researchers working on a number of projects including the first set of surveys designed to measure GNH. I applied to the CBS as a research intern, a program whereby academics can travel to Bhutan to conduct research relevant to the center's research goals.

Once I arrived in Bhutan in May of 2006, I was assigned a counterpart to assist me with my research. Generally speaking, a counterpart facilitates between the intern and the personnel at the CBS, makes travel arrangements within the country, obtains travel documentation, which are required for all areas of the country, with the exception of the route between Paro and Thimphu. My counterpart also acted as my linguistic and cultural interpreter. The collaboration between my counterpart and me became part of a rich, often frustrating, and ultimately insightful dialogue. In my naiveté I went to Bhutan with a view of myself as 'the researcher', the authority figure in the anthropologist-informant relationship. As I discovered, my counterpart had expectations of his own about the kind of research he wanted me to undertake.

In particular, he wanted me to teach him something about Bhutan, an expectation that at the time was perplexing because from my position, he was the expert on all things Bhutanese. He often told me that he wanted me to "do a good job". Negotiating my way through this collaboration was one of the most difficult aspects of doing research in Bhutan. There are many challenges when working with another person, which are compounded when you are working with someone from a different culture, where as a stranger to the country you must rely on your research collaborators to guide you through the unknown. Language, gender, individual expectations, as well as cultural norms and mores become part of the negotiation process between two individuals working together. Ultimately, you learn a lot about yourself and your abilities as a communicator and as a researcher. Despite the challenges, my counterpart made a significant contribution to this research. He generously brought me into a large social network composed of his friends, family, and acquaintances. As a result, this thesis is partially reflective of his social reality. Of particular importance was my visit to central Bhutan where I stayed with several members of my counterpart's extended family who welcomed me into their homes. I would like to thank them for their help, for making me feel welcome, and for their many cups of butter tea and ara.

The Limitations of Language

At the most basic level of analysis, culture and health care in Bhutan can be described as a combination of 'traditional' and 'modern' elements. But the long-established traditional-modern dichotomization does not adequately describe the range and diversity, the plurality, of practitioners who do the work of healing; nor does it describe the interrelated nature of different modes of healing and their connection to other social, cultural, and political spheres of experience. Rather than separate and self-contained health care sectors, Bhutan has a complex configuration of health care options whose boundaries are exceptionally permeable. This is due in great part to a unique socio-cultural make-up in which concepts of health and spirituality are inseparable. To quote the Director of the National Institute of Traditional Medicine, "the art of healing is a dimension of the sacred" (RGB 2005). But it is this very permeability that makes it challenging to describe health care in this country. I have discovered in the process of experiencing and then writing about health care in Bhutan, that traditional linguistic categories are inadequate when attempting to describe and discuss the interconnected nature of many elements in this rich and complex culture. Anthropology has traditionally relied on language that compartmentalizes and isolates spheres of experience like health and religion rather than illuminating interconnections and complexities. In the Bhutanese context, concepts of health, and the practitioners who provide health care, do not conform to the limited and often dualistic categories that we rely on to describe socio-cultural realities. 'Traditional', 'modern', 'religion', 'health', 'sacred', and 'secular' are categories that have been used to describe culture and health care in many societies that exhibit medical pluralism. These are conceptual and linguistic containers that imply a dichotomous and disconnected relationship between aspects of culture in Bhutan that are connected and interrelated on many levels. In speaking about the interconnected nature of religious and political structures in Bhutan, Michael Aris observes that "so fuzzy are the boundaries between the sacred and the profane that the two become confused, the one merging again and again into the other" (1987, 140-141). I too would suggest that the boundaries are fuzzy, and that conceptual categories like 'sacred' and 'profane' do not accurately represent the permeable and interrelated nature of religious and medical acts in Bhutan, or the nature and quality of Bhutanese realities.

Aris highlights a problem that is of special significance when working in a Buddhist context, a philosophical tradition that teaches a view of reality that is unfamiliar to Western-trained anthropologists. At its heart, Buddhism teaches philosophical doctrines that emphasize the interdependent and relational nature of all phenomena. For example, Buddhist monks and practitioners train the mind to cease dualistic conceptual thinking. Thus the language of culture in Bhutan cannot be fully represented by categories that we habitually use, like 'traditional' and 'modern', 'secular' and 'sacred'. But as Stacy Pigg points out, it is "curiously" difficult to eliminate such terminology from our vocabulary (1995, 50). Ideally, this research would include a language study to help elicit and better understand indigenous concepts of health, but because of the limitations on the duration of my stay, this was not possible. Thus, for the purposes of this paper, I must rely on language, which although not entirely representative, most closely relates to what I am discussing. I have chosen to use 'traditional' and 'indigenous' to describe Tibetan medicine in Bhutan because Bhutanese themselves refer to Tibetan medicine as both indigenous and traditional. I have also chosen use the term 'biomedicine' instead of 'Western' or 'allopathic' or 'cosmopolitan' because 'biomedicine' best expresses the "scientific" (Lock 1984, 121) disease-based tradition from which it comes.

The Study of Health Care Systems: A Contextual Approach

How to approach the study of health care systems has been at the center of a discussion by anthropologists researching medical systems. Peter Worsley suggests that anthropologists have tended to over-systematize (1982, 315) their field data, finding and imposing categories on the data that do not reflect the emic perspective; in essence mistaking the map for the territory. It is an issue that directly speaks to the anthropologist's role in constructing realities from field data that members of that society do not experience. I have taken an approach, following other anthropologists (Worsley 1982; Leslie 1980; Stoner 1986; Waxler 1984), which emphasizes health seeking behaviour as a very practical search for things that will make them feel well again, rather than an exercise in choosing between different theoretical models. My exploration of the health care system in Bhutan indicates that health seekers in that country *are* very pragmatic, flexible, and open to trying an assortment of treatment options in a complementary way. In addition, this approach tends to de-emphasize the particular 'system' from which health care treatment options may derive, instead identifying health care alternatives and describing the context in which they operate. As Bradley Stoner suggests, using this approach, medical pluralism can be "examined as a multiplicity of healing techniques, rather than of medical systems" (1986, 47). In line with other ethnographies of health care (Kleinman 1981; Lock 1980) I have emphasized the historical, religious, and cultural context of health care in Bhutan. Moreover, I describe available health care options and elucidate when and why individuals choose to use these options.

Whether we use the word "system", "configuration" (Press 1980, 47), or "sector" (Kleinman 1980) to define health care systems and their various parts, we are still left with the inadequacies of these categories, and the difficulties associated with labeling aspects of health related behaviour. This is particularly true when attempting to delineate and define health care systems in a cultural context like that in Bhutan where there is no distinction made between medical and religious spheres of experience. In thinking about health care systems, however, it has been helpful to have a model from which to interpret the *relationship* between components of a health care system. In this respect I have used Kleinman (1980) as a guide. Kleinman proposes that the health care system is a cultural system like other cultural systems, "which integrates the health-related components of society" (1980, 24). For Buddhist health seekers in Bhutan this includes all the norms, values, cultural symbols, institutions, power relationships, and social structural variables that are part of Bhutanese realities. Kleinman uses words like "holistic", "interrelated" and "interconnected" (1980, 24) when referring to how one should view components of a health care system in relation to the cultural context in which it exists. Without doubt an exploration of health care in Bhutan lends itself to this holistic approach. It is impossible to look at health care in Bhutan without first understanding something about the cultural context in which it exists. It is a country where religion and medicine are inseparable, where, from an emic perspective, sacred and secular are deeply interconnected, and where healing is the domain of a variety of practitioners. In essence I have taken the first steps in the process of creating a conceptual model of the health care system in Bhutan. Kleinman suggests that in order to construct a model of a health care system, the researcher needs to engage in the process of medical ethnography, so that local health care systems may be reconstructed (1980, 26). The data presented in this paper are the beginnings of just such a medical ethnography, and one that will continue to grow as more researchers explore health care in Bhutan.

Chapter 2

CONTEXT

In a recent publication examining cultural identity and nationhood in Bhutan, Michael Hutt observes that "it remains among the least-known of all the world's nation-states" (2003, 2), and that every writer who wishes to address a non-specialist audience must begin by introducing the country (Hutt 2003, 2). Indeed, there are very few instances when I have seen a look of recognition upon telling someone that I have been to a country called Bhutan. And so, my exploration of health and healing in Bhutan must also begin with an introduction to the history, culture, and politics of this tiny Buddhist kingdom. Much of what *is* known about Bhutan comes from travelers and journalists who invariably liken it to the mythical land Shangri-La, a place that was imagined by James Hilton in his fictional account of travelers who come upon a hidden valley deep in the Himalayan mountains. Hilton's novel *Lost Horizon* describes a place where the characters discover a land of everlasting peace, harmony, and happiness. But the idea of Shangri-La comes from Tibetan Buddhist mythology. Tibetan Buddhism teaches of secret valleys or *beyul,* which are said to be sealed from the outside world and only accessible to those who have reached a certain level of spiritual Enlightenment (Zeppa 2006, 20). Shambhala is the most venerated and famous of these valleys and it was Shambhala that was probably the model for the utopia that Hilton describes in his book (Hutt 2003, 280).

Bhutan is often referred to as the last Shangri-La, and is represented as a sanctuary that is unspoiled and untouched by the worst elements of development and modernization. “Bhutan as Paradise” (Zeppa 2006, 20) is a powerful representation that has been perpetuated and promulgated by visitors, journalists, development agencies, and the Bhutanese government. It seems that each of these groups has a stake in maintaining an exoticized version of the country. In one sense, Bhutan is the repository for many of the hopes and fears that people have about change and modernization around the globe. There are many who see it as a country where development has gone right, and certainly the Bhutanese government has embraced this version of itself and promoted it to the outside world, especially to the West (Hutt 2003, 271), an important source of tourism revenue and development partner. The reality is that Bhutan has gone through a rapid transformation in a few short decades, from Buddhist kingdom to nation state, and has been subject to pressures of a geopolitical nature throughout its history, primarily from China and India. To defend against threats to its sovereignty and to cope with rapid change, the country has had to redefine itself, creating a new national identity and development discourse focusing on the country as a happy, pristine place; the birthplace of Gross National Happiness. But as I, and others have observed (Hutt 2003, 271), Bhutanese realities as they are actually lived and experienced are quite different from the representation. For example, when I spoke to people about GNH, many of them could not understand how it would really impact their lives in a practical way; some even described it as government propaganda. Historically, Bhutan has always proceeded cautiously, demonstrating a preference for isolation, perhaps one reason for its distinct identity as the ‘Last Shangri-La’.

After two expeditions to Bhutan, Michael Ward, a surgeon and mountaineer expressed his feelings about Bhutan this way: “The most poignant aspect of this beautiful and ageless land lies in the contrast between the serenity of life within the country and the turbulent forces that surround it” (1966, 504). Ward’s comment reflects both the romanticized version of Bhutan and the reality of the country’s precarious geopolitical situation. Bhutan is a small country located in the folds of the southern slopes of the Eastern Himalayan range. It is bordered by Tibet in the North and India to the East, West, and South. By most standards it is a small country: larger than Belgium or Holland, smaller than Austria or Portugal, and barely one-third the size of Nepal (Hutt 2003, 3). The country is largely mountainous; the only ‘lowlands’ are located in the South on the border Bhutan shares with India. Due to the varied topography the climate and vegetation are incredibly diverse. In most northerly regions it is high, cold, and barren, while regions to the south are populated by thick stands of pine forest and rhododendron. Further south and east there are subtropical areas containing some of the richest and most diverse flora and fauna in the world. Bhutanese people have always been resilient, negotiating the country’s challenging topography on foot. The country is sparsely populated, and estimates of the total population ranges widely, from 552, 996 (Kuensel 2006a) to 930,614 (Rose 1977, 41), depending on the source. At present, the exact proportion of the population who can be labeled Bhutanese remains contested (Hutt 2003, 5), a fact that may account for the discrepancy in the population census numbers. As Michael Hutt points out, politics in the country are increasingly ethnicized (2003, 4), a trend that revealed itself most dramatically in the early 1990s with the apparent expulsion of so called 'ethnic Nepalis' (Hutt 2003, 5). The origins of the government's protectionist attitude toward Bhutanese identity and selfhood, however, can be found in the country's centuries-old history.

Bhutan's Historical Background

History in Bhutan is generally divided into two segments, Buddhist and pre-Buddhist. The country's early pre-Buddhist history is largely obscure and historical records essentially begin with the introduction of Buddhism. It is believed that sometime in the eighth century, the Tantric sage Padmasambhava visited Bhutan. In Bhutan, Padmasambhava is better known as Guru Rinpoche, meaning 'precious master'. Padmasambhava is considered the patron saint of Bhutan and is also referred to as the second Buddha; second only in importance to Gautama Buddha because it was Guru Rinpoche who introduced Mahayana Buddhism to the country (Dorji 1995). Guru Rinpoche is associated with many historical sites in Bhutan and also with a number of religious treasures, which he hid in various locations around the country to be found and interpreted by special treasure-hunters or *tertons* at some future date. Guru Rinpoche is best known for flying to Taksang or 'Tiger's Nest', an impressive monastery perched on a cliff above Paro valley. According to legend, he flew to Taksang from Tibet on the back of a tigress and then traveled to Eastern Bhutan where he slew a powerful deity. This story is at the heart of Bhutan's mythical-religious history.

From the tenth century until the early seventeenth century Bhutan's history is marked by conflict between various Buddhist sects and the powerful families who supported them. Religious and political power came to be concentrated in the hands of reincarnating monk-rulers. As a Leo Rose (1977) asserts, Bhutanese political history has always been closely linked to its religious history. Eventually the various principalities were united, after much conflict, under the guidance of Ngawang Namgyal, a member of the Drukpa Buddhist sect, which came to dominate the country. Today, the Buddhist peoples of Bhutan are generally referred to as Drukpas. Giving himself the title of 'Shabdrung', Namgyal became the spiritual and temporal head of a united Bhutan (Rahul 1997, 2). The country then became known as Drug Yul, meaning 'Dragon Country'. At his death in 1652 the Shabdrung controlled all of Western Bhutan and much of Eastern Bhutan as well. An important aspect of the Shabdrung's rule was that he established the authority of the Drukpa Buddhist sect throughout the country and governed as a Buddhist ruler, overseeing both religious and secular affairs. Following Namgyal's death, succession to this theocratic system was determined through the reincarnation process, a predominant feature of Buddhism in Bhutan and Tibet. The country was ruled by a series of religious and secular heads of state, also referred to as Shabdrung, until 1907 when Ugyen Wangchuck, a powerful local ruler, established his authority over the country. Wangchuck was enthroned in as the first hereditary King of Bhutan in 1907, placing Bhutan under the control of a single family, an event that has dramatically shaped the country's social and political makeup.

Despite its many romanticized representations, Bhutan *is* a unique country with a distinct history. Michael Aris has described Bhutan as distinct, especially with regard to its survival as an independent state in a region where other Buddhist states have disappeared (1987, 133). It is one of the world's last remaining Buddhist kingdoms, and as Aris suggests, has survived not by accident, but as a result of its own internal development (1987, 133). For many centuries the country nurtured what Syed Aziz-al Ahsan and Bhumitra Chakma have called a policy of withdrawal from international politics "to preserve its independence and distinct identity" (1993, 1045). Despite the country's historical preference for isolation, Bhutan has very quickly embraced and encouraged the process of change and modernization. Out of necessity, these changes have occurred in a matter of a few short decades. Bhutan sits in a strategically sensitive area between two powerful Asian nations, China and India. As these two giants have grappled for dominance in the region, Bhutan's sovereignty and independence have been challenged. In 1958 for example, a Chinese magazine printed a map showing a part of Bhutan within China's borders (Ahsan and Chakma 1993, 1043). Poorly drawn maps have contributed to a situation in which negotiations with China over boundary lines between the two countries are still ongoing.

Similarly, Bhutan has historically been a part of an Indian "sphere of influence" (Ahsan and Chakma 1993, 1044), serving as a buffer between India and China, both during the British colonial period and after. During the colonial period in India, Bhutan agreed to be guided by the British in matters relating to external affairs. Susan Neill describes the relationship between Britain and Bhutan as "colonial only insofar as Britain sought authority over Bhutanese territory" (1997, 48), indicating that the British had no influence over Bhutan's internal affairs. When the British finally left India in 1947, Bhutan remained under the protection of the Indian government. The 1949 Indo-Bhutanese Treaty obligates "Bhutan to seek Indian advice on its foreign relations but does not obligate it to accept it" (Ahsan and Bhumitra 1993, 1043). The relationship between India and Bhutan remains "warm and cordial" (Chhetri 2005). India is the single largest donor in economic aid to Bhutan as well the most significant contributor to the development of the country's infrastructure and military. Early in the country's history, Bhutan's close relationship with India allowed the country to remain quietly aloof from the rest of the world until the 1950s and the Chinese occupation of Tibet. Bhutan's policy of isolation was shaken, and as Ahsan and Bhumitra suggest, "The Tibetan episode made Bhutan realize that its detachment from the world might cost it its independence" (1993, 1045). Out of concern for its own survival, the country began what has been called a "radical period of modernization" (Neill 1997, 50). Under the direction of the third King, Jigme Dorji Wangchuck (1952-1972), Bhutan changed very quickly with the introduction of major social and political reforms. Jigme Dorji Wangchuck created a National Assembly, abolished serfdom, and introduced land reform. He also created a mass education system and added health care to a list of national priorities. Jigme Dorji Wangchuck has been called the architect of modern Bhutan (Mathou 1999, 614). And it was King Jigme Singye

Wangchuck, who first articulated a new approach to development in Bhutan, stating, "Gross National Happiness is more important than Gross National Product". Many consider GNH a revolutionary and more humane approach to development, one that focuses on "genuine sustainable humane development, rather than just income growth" (Mathou 1999, 615). Gross National Happiness (GNH) can be defined as a development strategy which uses happiness as the ultimate measure of the successfulness of Bhutan's development plan (Thinley 1999). In a policy document outlining Bhutan's vision of development for the country, GNH is defined as a "unifying concept"; a statement about Bhutan's commitment to spiritual growth and the importance of maintaining a balance between material wealth and spiritual fulfillment (RGB 1999, 10-11). The concept is bound up with Bhutan's Buddhist ideology, which promotes balance as one of its main tenets and emphasizes other principles like conciliation, pragmatism, and compassion (Mathou 1999, 617). Through GNH, the government is attempting to create the right environment for Bhutanese citizens to seek happiness. As part of this promise, King Jigme Singye Wangchuck initiated reforms setting Bhutan on the path to democratization, which he has said is the way to good governance, one of the pillars of GNH (Kuensel 2007). Thus for Bhutan, democracy is not *the* goal, but rather a means to Bhutan's own development objective, GNH (Kuensel 2007). In 2005 King Jigme Singye Wangchuck unveiled a draft constitution, which introduced democratic reforms to the country. But for a populace whose political consciousness has been described as low (Mathou 1999, 616), and who hold the monarchy in a reverent regard, the shift to democracy will require a transitional period (Mathou 1999, 623). There is no doubt that the country will build its own brand of democracy, and that it will be intertwined with its unique social and political heritage. Bhutan's first general election is to be held in the spring of 2008 on specific dates that have been carefully selected by the country's royal astrologers. National elections will mark a new chapter in an ancient history, where the country's traditional religious and cultural values of pluralism, diversity, and flexibility will be tested once again.

Tibetan Buddhism: The Philosophical Context of Health Care

Tibetan Buddhists in Bhutan are part of a larger Tibetan community. In addition to Bhutan, Tibetan Buddhist societies can be found in the Tibet Autonomous Region, India, and Nepal. These communities share a common religious, cultural, and political heritage. Tibetan Buddhism is a distinct form of Mahayana Buddhism that is shamanic in nature, meaning that practitioners communicate with deities via altered states of consciousness induced through Tantric yoga practices (Samuel 1993, 8). There are two groups of Tantric practitioners, those who observe monastic vows and those who do not. As Michael Aris points out, however, it is the inclusion of many types of professional, non-celibate religious practitioners, in a religious system that was previously dominated by fully ordained monks, which makes Tibetan Buddhism, like that practiced in Bhutan and Tibet, so unique (1987, 138). Thus pluralism is present in the number and variety of Tibetan Buddhist sects and also at the level of the practitioner.

With respect to Buddhism in Bhutan, Mark Mancall has noted that Buddhism and Bhutanese culture are almost "isomorphic" (2004, 26). The Tibetan Buddhist world in Bhutan is filled with spirits, deities, demons, enlightened beings, and sacred sites. Geoffrey Samuel refers to this world as the "sacred geography" or "ritual cosmos", and it is the ground on which people position themselves in relation to the universe (1993, 157). It is a complex spiritual life-world that goes beyond the scope of this paper, but which I will present in brief because in many respects it is virtually inseparable from other aspects life, including health. Tibetan Buddhists in Bhutan, like those in Tibet have inherited a complex model of the universe from Indian forms of Buddhism. The Buddhist universe includes both heaven and hell realms with a universal axis at its center. heaven and hell are further divided into many different realms, hell for example is divided into realms of hot and cold and graded in terms of intensity of punishment and the duration of stay (Samuel 1993,158). Another important aspect of Buddhism is the Tibetan Buddhist 'Wheel of Life', which depicts in detailed pictorial form the different modes of rebirth into the various realms that make up the universe. Gods, demigods, human beings, animals, hungry ghosts, and hell-beings are part of the ongoing cycle of birth, death, and rebirth. Each group inhabits a sector of the wheel where all of these beings revolve continuously, and possibly for an eternity, until they are able to exit the cycle of rebirth by pursuing and eventually attaining the goal of Enlightenment.

Depictions of the 'Wheel of Life' can be found all over Bhutan. They are on chortens (reliquary monuments), which often contain relics from great lamas, as well as temples whose centuries-old walls are covered in colourful representations of these realms and their inhabitants.

Contemporary Tibetan Buddhism is the result of a melding of Buddhism and various folk beliefs (Tucci 1970, 29). With the introduction of Buddhism to Bhutan, many local and regional deities were incorporated into the Buddhist pantheon. Tibetan Buddhists distinguish the local deities from two other groups of deities: the Tantric gods associated with Buddhist meditation, and the gods of the Buddhist heaven realm (Samuel 1993,163). Tantric deities are accessed and evoked using Tantric practices performed by lamas and experienced practitioners. The simplest way to distinguish between local and Tantric deities, as my counterpart explained to me, is that local deities are generally called upon to help with health and good fortune in this life. Tantric deities, on the other hand, are the purest expressions of universal human potentialities. For example, the Tantric god, Avalokiteshvara is the embodiment of compassion. Many Tantric deities can only be accessed by lamas or other experienced Tantric practitioners because they are considered too dangerous for novice meditators. But Avalokiteshvara and deity figures like Guru Rinpoche are also popular devotional deities for the lay population. Many temples in Bhutan contain large statues of Guru Rinpoche where people go to pray and make small offerings of food and money. Tantric or local, these deities are part of the Tibetan Buddhist religious complex. As I shall explain in the chapter on lamas, Tantric and local deities are within the lamas' sphere of influence and control. Lamas are often called upon to intercede for an individual who has been attacked or made ill by a malevolent spirit.

Your Karma is Your Health

Speaking with a high lama at an important monastery and meditation center, he told me that to be born human is an extremely lucky event. As a human, there is the opportunity to be aware, to be spiritual, and to demonstrate compassion to others. For these reasons, a human birth is not to be taken lightly, because with awareness comes the possibility of accumulating merit, and by generating enough merit or good karma an individual may create a favourable set of conditions for his or her next life. Living this life and preparing for the next is part of the circle of karma (Choden 2005), a premise that is the basis of the Tibetan Buddhist life-world. It is a concept that is also very much bound up with Buddhist concepts of health and wellness. Geoffrey Samuel explains the concept of karma this way:

> 'Merit' and demerit, good or bad karma. form the foundation of the Buddhist ethical code, which is justified by reference to the immutable laws of cause and effect. According to this law of karma one's actions in this life, or more precisely one's intentional states, have effects in future lives, just as one's fortune in this life results from the karma of one's past actions. (1993, 25)

Simply put, karma is the law of cause and affect. Tibetan Buddhists in Bhutan are keenly aware of their moral and ethical behaviour, because actions and thoughts have consequences for this life and the next. In an absolute sense, karma dictates the health we experience and is also the source of all sickness. Good karma can result in an auspicious rebirth and a life of fortune and good health. Any illness or injury experienced in a current incarnation may have been caused by non-virtuous actions or thoughts in a past life, or perhaps many lifetimes ago. Good karma leads to good health, whereas negative karma, given the right set of circumstances can manifest as poor health. As Dr. Chencho Dorji, the sole psychiatrist in Bhutan reported to me, it is believed that most illnesses are the consequences of bad virtue or wrong attitudes; in other words negative karma.

Thus, the purification of negative karma is the path to health, long life, and ultimately, to Enlightenment. The longer an individual is able to practice the Buddha's teachings, free from illness, the better the chance that he or she will collect merit over a lifetime and receive a favourable rebirth. The Buddha is often referred to as 'The Great Physician' because for practitioners, it is only through his teachings, through the Dharma, that one may ultimately free one's self from suffering. One way that Tibetan physicians help patients is by removing 'obstacles', in the form of illness, which prevent individuals from practicing the Dharma.

The Buddhist concept of impermanence provides a sense of urgency to practice and is the driving force behind the emphasis on practicing now rather than later. Only your accumulated merit and an understanding of the Dharma will help you once the moment of death comes. Practice is a part of life for Buddhists in Bhutan and can be observed on a daily basis. Virtuous behaviours that garner good karma can include giving money to a monastery and repairing or building religious structures like chortens or mani-walls (prayer walls); merit may also be accrued by becoming a monk or observing the precepts as a lay practitioner on a temporary or permanent basis; reading scripture and sponsoring the printing of religious texts also generate good karma. Another extremely meritorious action includes pilgrimage, which is often undertaken by older Bhutanese. It is common for older women, usually widows, to devote themselves to Buddhist practice by either becoming a nun or observing lay precepts. They are often in their seventies or eighties whey they go on pilgrimage, walking great distances to sacred sites in Bhutan and Tibet. Going to the local temple to make offerings and pray is a daily activity for many Bhutanese. Prayers and offerings are also made to household shrines.

The National Memorial Chorten in Thimphu is a site where people of all ages practice fervently. Circumambulating the National Memorial Chorten, located in the center of Thimphu, Bhutanese of all ages count prayer beads and recite mantras as they walk around. Individuals may also perform full body prostrations on a long wooden board. Depending on the seriousness of the perceived fault or action, an individual may perform 100 prostrations or as many as 600. Good behaviour toward one's fellow human beings and to all living things is important and considered a 'karmically positive' action. For devout Buddhists eating meat generates negative karma. A butcher who slaughters animals will be affected by this non-virtuous act in his next life, but those who eat the meat may also suffer the consequences. English speaking Bhutanese often describe committing such non-virtuous acts as 'sinful' behaviour. In speaking with people about their health and inquiring about the cause of an illness, many related falling ill to the accumulation of negative karma in a past life. For many Tibetan Buddhists, accruing merit and achieving a balance between positive actions and their non-virtuous deeds is of primary concern; that and the hope of a rebirth that is relatively free of illness, hardship, and suffering. These beliefs about health and karma are the backdrop for much of the health seeking behaviour in Bhutan.

Spirits and Deities: In Sickness and in Health

Encounters with spirits, demons, and deities are part of a shared experience as a Buddhist in Bhutan, and most Bhutanese can tell you about these encounters. Despite the historical 'taming' of these beings by the Buddhist saint Guru Rinpoche, they continue to impact the lives and health of Buddhists in Bhutan. Evidence of spirits and deities are often reflected in the natural world. For instance, one young man told me about a tree in his village, which became the focus of a struggle between a demon and a deity. The young man recalled that according to eyewitness accounts, a deity appeared in the form of a large bolt of lightening, chasing a demon into a large tree in the center of the village. Frightened, the demon hid inside the tree, but the deity was too powerful and collided with the tree, defeating the demon within. To this day, the tree has a large scar, a reminder of the battle between the demon and the deity. The Naga or snake deity is another type of spiritual being commonly encountered. Naga are known as moody and mischievous spirits; they often reside near houses and are associated with large stones that have unusual characteristics. They can be harmful but are generally appeased by regular ritual offerings. Stories abound of children playing around or climbing on these stones without realizing their importance and getting sick as a result. I interviewed two individuals who encountered a Naga spirit. One woman reported that as a child, she disturbed a Naga living near her home and developed a serious rash on her face as a result; unexplained rashes are an indication that you may have upset a Naga. The woman's mother appeased the Naga by performing prayers and a ritual, which included washing the rock where the spirit lived with milk. After a day or two, the woman's rash disappeared.

In a similar case, a woman described experiencing a serious allergic reaction, which sent her to the hospital. I asked her why she believed this happened and she recalled that she had been neglecting her ritual duties. She said her father gave her the duty of taking care of the Naga, which required her to leave offerings for it on the eighth day of every month. This particular Naga lived in a large rock on which a small chorten had been built. The woman reported that once she began making regular offerings again, the allergy disappeared. The ritual maintenance of spirits and deities like Naga is an important aspect of ensuring physical, mental, and social well-being for Buddhists in Bhutan. Spirits like Naga can also bring good luck, wealth, and health if shown care and respect.

Malevolent spirits can be the cause of serious illness when they attach themselves to objects, individuals, or to an entire household. It was reported to me that if a lama does not remove a spirit, its presence could cause death. Spirits often inhabit lakes, which are marked by small stone cairns. Many people report experiences with spirits around lakes. They seek revenge on hapless individuals who attempt to fish from them. Above Thimphu, there are a series of lakes that are well known for the spirits who live in them; the lakes can be seen on a well-traveled trail known as the Druk Path, a hike that takes you high above Thimphu and passes through what used to be one of the richest and most powerful monastic centers in the area. Unfortunately, the monastery is now crumbling with neglect. Before the road system was built in Bhutan the Druk Path was one of the most direct routes between Paro and Thimphu. It is a six-day walk that ascends and descends over mountain passes, through yak pasture, and rhododendron-covered ridges. Like trails throughout Bhutan, the Druk Path is periodically marked with stone cairns and chortens, which guide the traveler safely through this "sacred geography" (Samuel 1993, 157). As Geoffrey Samuel asserts, for Tibetan Buddhists, these structures are symbolic of the sacred landscape, "recreating the structure of Tibetan religious meanings" (1993, 159). Tibetan Buddhism is grounded in associations with symbolic devices like cairns, chortens, prayer-walls and flags, temples, and monasteries (Samuel 1993, 159). Human beings are active participants in this universe, one filled with potentially harmful beings. Each time an individual places a small stone or flower on or next to a cairn, they are participating in and "reactivating" (Samuel

1993, 158) their place in the universe. The offering acknowledges the presence of a powerful spirit or deity residing nearby and ensures a safe journey.

Deities can be male or female and are visited for various reasons including health, the maintenance of good fortune and protection from harmful spirits. Local gods are often consulted through the practice of divination to determine whether circumstances are favourable for activities like building a new house or chorten, or going on a trip. As Samuel states, "One needs to know whether one's proposed action is harmonious with the total situation" (1993, 192). Burning Juniper branches, incense, and making offerings to local deities encourages the auspicious outcome of an undertaking. To discover the source of a problem or predict the outcome of an activity or journey, an individual can visit a temple where a deity resides and ask the services of a monk or lama. One of these services includes dice; a set of die are presented on a tray and rolled by the person seeking help. The dice indicate whether the deity is well inclined to the proposed activity or project. Local deities, some of whom predate the arrival of Buddhism, are often associated with Buddhist temples or Lhakhang. Lamas and monks at these temples provide a wide range of services in the community, for this life and the next; they communicate with local and Tantric deities and perform services, which can include divination, astrology, and Tantric ritual. I asked my counterpart in what circumstance a person would make offerings to a local deity versus a Tantric deity. He explained that people pray to local deities for help in their current life, whereas people pray to the Buddha for good karma in their future lives. Thus people seek out local deities for very pragmatic reasons. For instance, I visited a temple or Lhakhang above Thimphu where families bring their newborn children. Newborns are brought to be blessed by the lama and to receive a name. One man I spoke to brought his newborn because the baby would not stop crying at night. The man reported that he was hopeful that by bringing the child to the deity, she would begin to sleep peacefully.

There are some deities that women cannot access directly. I visited a particularly powerful male deity whose residence was inside a cave-like opening in the mountainside. I was not allowed to enter the deity's sanctuary because his power was not compatible, so to speak, with feminine energy. My counterpart warned me that if I were to enter the deity's sanctuary, I would become ill and experience sleep disturbances. However, I observed many women leaving offerings, which were placed near the statue of the deity by a monk. It is common practice to bow to the deity, pray, and offer mantras. Several people also reported to me that certain deities are well known for curing diseases like cancer, Parkinson's, and leprosy.

Interestingly, after spending some time in Bhutan, the prevalence of signs and omens indicating fortune and misfortune started to affect how I thought about my own good fortune, or lack thereof, as I dealt with the challenges associated with my fieldwork. The week I spent in Ura, for example, was particularly challenging because of a series of events I perceived as signs of bad luck. I began to believe that I was traveling at a particularly inauspicious time. In that moment, I grasped new insight into my supposed objectivity as a researcher, into the scientific nature of anthropology, and a methodology that imposes distance between ethnographer and subject; I was able to explore my own beliefs (Favret-Saada 1980) about many elements of Buddhist culture and think about how to present my field data without sounding credulous. As Jeanne Favret-Saada suggests in her ethnography on witchcraft in the Bocage, "to say that one is studying beliefs…is automatically to deny them any truth" (1980, 4).

Spirits, deities, and demons are part of a broader Tibetan Buddhist religious complex, which can be found in other Tibetan cultural communities like those in the Tibet Autonomous Region, India, and Nepal. Encounters with these beings are part of a shared experience as a Buddhist in Bhutan and is one aspect of a shared reality between members of these different communities. The ritual maintenance of spirits and deities is deeply connected to health and well-being on an immediate level; should an individual neglect her ritual duties with respect to a spirit, the consequences are almost instantly experienced. However, within this sacred universe human beings are not helpless. Through individual agency, Tibetan Buddhists can appease potentially harmful beings by observing ritual protocol. This may be as simple as placing a small rock or flower on a cairn to ensure a safe journey. Buddhists may also turn to Tantric practitioners and lamas who are skilled in communicating with these beings through a variety of techniques. These practitioners are the conduit between the world of everyday experience and alternative mode of reality. From a contextual perspective, an understanding of the role of spirits and deities in the lives of Buddhists is essential when examining concepts of health, as well as explanations for health seeking behaviour; they are part of the socio-cultural framework in which health care takes place in Bhutan.

Chapter 3

MEDICAL PLURALISM

The Government of Bhutan has endeavored to provide universal health care to a country where there are serious challenges to the provision of adequate medical services. In a country that has been described as "unremittingly mountainous" (Hutt 2003, 3), the equitable distribution of health care remains of primary concern to the government and to development organizations working in the country. Although Bhutan has a small population, many people live in small rural villages that are a significant distance from medical services; the 2005 population and housing census reports that 69.1% of the population lives in rural areas while 30.9% live in urban centers, and that roughly 15% of the population lives within 1-4 hours walking distance from a road while an equal percent live four or more hours from a road. The road system has improved immeasurably in the last few decades, but many still have to walk from their village to the road, a journey that may take several days. Although tourism advertising suggests that the country is a place of boundless beauty, prosperity, and happiness, Bhutan has many of the same problems faced by other countries with a shortage of basic medical services. Children succumb to malnutrition, dysentery, and diarrhea everyday, and for many, grinding poverty is an impediment to lasting good health. Nevertheless, the government is determined to, in essence, make GNH relevant to the entire nation by providing free and equitable access to health care, thereby creating the conditions under which well-being may be achieved and happiness pursued.

The Ministry of Health stipulates that the Bhutanese health sector endeavors to bring good health to the population, and to do so within the broader framework of social justice. The Ministry of Health outlines the vision for health care in the country, which is to

> Build a health and happy nation through a dynamic professional health system, attainment of the highest standard of health by the people within the broader framework of overall national development in the spirit of social justice and equity. (MoH 2007)

In a few short decades this has become Bhutan's philosophical and practical approach to health care. The above statement from the Ministry of Health is reminiscent of GNH and the balanced approach the government has adopted toward development in Bhutan in general. Like GNH, this philosophy of health care reflects aspects of Buddhism: balance, social and emotional well-being, and compassion. These are aspects of Tibetan Buddhism, which permeate all levels of Bhutanese society. The introduction of biomedicine to a developing country is often associated with the perceived death of any pre-existing system of traditional medicine; but rather than marginalize Tibetan medicine, which has been practiced in Bhutan since the seventh century, the government is continuing to look for ways to further partner Tibetan medicine and biomedicine, thus cultivating and fostering pluralism in the medical system.

Health care is a crucial component of a national development strategy that encourages the protection of traditional culture while embracing, what the government perceives, as the most useful medical technology and methodology the West has to offer. In a mere 30 years, the biomedical health care sector has matured and is offered to health care seekers on a large scale. Biomedicine is now an accepted and highly utilized component of the country's health care system. The Ministry of Health is also actively promoting the use and growth of traditional medicine as a viable self-sustaining health care option, one with the potential to generate income through the sale of Tibetan pharmaceuticals to international markets.

It is difficult to determine when biomedicine was first introduced to Bhutan. According to the Ministry of Health there are a few very early reports of Indian physicians and paramedics practicing Western medicine in the country in the early part of the twentieth century (MoH 2007). The Indo-Bhutan Friendship Hospital in Thimphu, built in 1970, is a testament to the close relationship that India has with Bhutan. Moreover, India continues to be a development partner in Bhutan's health care system. A new hospital facility is currently being built with considerable assistance from the Indian government. It is clear that by at least the middle of the twentieth century, Bhutan had been introduced to biomedicine (RGB 1997). In 1964 and 1965 Michael Ward, a consultant surgeon, mountaineer, and explorer conducted a survey of north and northwestern sections of the country. In his report, he states that the few hospitals that Bhutan possessed at that time were being enlarged, evidence of a country in the initial stages of development (Ward 1966, 492).

Health care infrastructure began to expand significantly in the 1970's when Basic Health Units (BHUs) were established (RGB 2002, 76). Structurally speaking, primary health care is delivered to the country via a four-tiered health care system, which consists of The National Referral Hospital, Regional Referral Hospitals, District Hospitals, Basic Health Units, and Out Reach Clinics. At the grassroots level the government is developing a system of Village Health Workers (VHWs), community members trained as health educators. They provide information on topics like hygiene, sanitation, family planning, nutrition, and STD/AIDS prevention. VHWs are also equipped to treat simple ailments and injuries including worms, scabies, headaches, gastritis and chronic pain. VHWs mobilize community support for health activities like immunization schedules for children and pregnant women. Based on the severity of the ailment VHWs may refer cases to a BHU or to a hospital for additional treatment. VHWs are an important human resource for the provision of basic health care.

Basic Health Units are a primary level institution and provide health care at the village and community level. They service populations of 1,500-5,000 and deliver basic health care services including, general advice on health and hygiene, vaccinations, basic laboratory services, and health care for newborns and mothers; individuals with serious medical conditions are referred to a district hospital and then to Jigme Dorji Wangchuck National Referral Hospital, depending on the severity of the ailment. BHUs are staffed by a Health Assistant, a Nurse Midwife, and a Basic Health Care Worker. Many BHUs house biomedical services and traditional health care services in the same facility. Each BHU also has an average of 3-6 Out Reach Clinics (ORCs), which deliver health services to the most isolated villages. Following the WHO-UNICEF Alma Ata Declaration in 1978, in which "health for all" was proposed as the guiding principle for health care delivery, the Primary health care (PHC) approach was formally adopted in Bhutan in 1979 (RGB 2002, 76). According to the Alma Ata Declaration, "primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO 1978).

And further, the goal of PHC is to bring health care "as close as possible to where people live and work" (WHO 1978). The model proposed by the Alma Ata Declaration suggests that health care delivery should be equitable and universal, geographically accessible, and most importantly have substantial community involvement. The primary health care model also promotes the development of the education system, food security, clean drinking water, sanitation, family planning, vaccination, and the provision of drugs and health services for all. Primary health care is part of a whole development package that encompasses and encourages economic and social development alongside the health care system.

The PHC model also promotes the participation of traditional practitioners. The country actively promotes traditional medical services and maintains a formal commitment to its growth and development. Policy documents like Bhutan Vision 2020 call for more effective integration of traditional medicine into the health care system, to provide a health care alternative for those who seek one (RGB 1999, 23). In addition, the Eighth and Ninth Five-Year Plans strongly suggest the need for further development and integration of traditional medicine into the medical system as a whole, so that individuals receive some form of health care should they choose not to access biomedical services as a primary health care option; ideally, the two systems operate in tandem through a system of cross-referral. Following this policy of pluralism, the government has placed traditional medicine units in all 20-districts and is planning to establish similar units in all BHUs in the country (RGB 2005,13). Thus the government has very consciously placed traditional medicine alongside biomedicine as part of its development effort.

According to the Ninth Plan Health Sector document there are approximately 1.7 Doctors per 10,000 people. The shortage of trained personnel within the health care sector is one of the obstacles to the PHC model in Bhutan today. Because of this shortage, Bhutan still relies heavily on the expertise of foreign volunteers and consultants. One of the goals outlined for the health sector in Bhutan's Vision 2020 document is to reduce the dependence on the assistance of expatriates living and working in the country by training more Bhutanese health personnel. Financing the health system is of primary concern because of the country's small economy. Bhutan relies on donor countries to help finance the health sector. Partnerships with The Government of India, DANIDA, WHO, UNICEF, UNFPA and JICA are expected to continue as

Bhutan continues to grow the health care sector. In addition to ongoing external assistance, Bhutan plans to gradually introduce user fees that will support the high cost of health care. It is still unclear as to what areas of the health care system will be subject to user fees, although some have already been applied to selected dental services. Policy documents suggest that user fees will be introduced for those who are able to meet some of the costs of health care, starting in urban areas (RGB 1999). Fees will be linked to people's ability to pay while at the same time preserving the principle of free health care for all. The government has also suggested the introduction of privatized health care so that those who are able to pay for the full costs of health care no longer receive it free of charge (RGB 1999, 23). This is a concept that may take years to introduce considering that most of the population is still living in poverty. There is however, a growing upper-middle class in Bhutan who may, in the coming years, be willing to pay for private health care. Although there is, as of yet, no socio-demographic data that examines class structure in Bhutan, in speaking with people, I observed that many in this socio-economic bracket already travel outside the country, especially to India and sometimes as far as Bangkok to receive surgical care and other specialized medical services for which they pay. Nevertheless, as it stands in Bhutan today, about 90% of the population is within three hours walking distance from medical services (RGB 2002).

As a result of a carefully planned and monitored health care system, and improved infrastructure like roads and highways, life expectancy at birth has improved dramatically, from an average of 47.5 years in 1990 to 61.1 years in

2000. In addition the under five mortality rate has decreased from 123 per 1000 live births (1990) to 84 out of 1000 live births in 2000. As the ninth five-year plan suggests, however, these numbers are expected to be lower by the end of 2007. Clean water is also a major concern for the country. Many areas are quite difficult to access because the entire country is extremely mountainous. However, 84% of the population now has access to clean drinking water, a great improvement from 1990 when only 45% had access to clean water sources.

Bhutan is also one of 191 nations who adopted the United Nations' Millennium Declaration, a broad set of development goals targeting, among other things, improved mortality rates and disease control. These targets correspond with indicators that came to be known as the Millennium Development Goals (MDGs). Bhutan has a commitment to meeting Millennium Development Goals it has set for itself. The government hopes to reach these goals by 2015, the date set by the Millennium Declaration as the end date for the current challenge.

Primary health care in Bhutan today is an integrated and pluralistic approach whereby all available resources are brought to bear on the provision of health care in the country. This includes traditional and biomedical practitioners as well as professionals and community advocates. Bhutan has demonstrated a commitment to continuity, through the growth and development of a traditional medical system that was present in the country before the arrival of biomedicine. As a whole, the country's health care system is firmly rooted in a philosophy of health care that is Buddhist in nature, reflecting Bhutan's adherence to Buddhist values like compassion, equanimity, and indeed happiness.

Through partnerships with various key development agencies like United Nations and the World Health Organization, the government seeks to continue its capacity building efforts in the health care sector, and to do so on multiple levels. Given the difficulties associated with Bhutan's challenging geographical make-up and a shortage of health care personnel, Village Health Workers, traditional practitioners, and physicians trained in biomedicine are of equal importance to the health of the country's population and to the continued success of the primary health care model.

In this chapter, I explore three health care options available in Bhutan: Tibetan medicine, Tantric healing, and biomedicine. I found that health care options are highly interconnected. In particular, Tibetan medicine and Tantric healing practices performed by lamas may represent versions of a single philosophy and methodology of health care, rather than separate medical systems. Indeed, this research suggests that the differences between them may be one of emphasis. I spoke with health care users who defined Tantric healing as the "religious side" of healing, and Tibetan medicine as a less religious and more medicinal option. There may also be class-based differences in how Bhutanese define and use the two types of practitioners. In any case, both emerged out of the Buddhist philosophy and therefore, are in many respects quite similar. But an important question remains as to how to label these two related health care practices. There is no doubt that with the rapid changes occurring in Bhutan, these traditional practices will also change and require redefinition in the years to come. I also show that biomedicine, as a medical system, is also highly permeable, demonstrating some intriguing connections between it and Tibetan medicine and Tantric healing. In Bhutan there are clear and observable exchanges taking place between such differing medical cultures as Tibetan medicine and biomedicine. These observations offer an intriguing preliminary glimpse into the nature of medicine and medical systems in a culture where there is little distinction made between religious and medical spheres of experience. I suggest that this research may call for a reexamination and redefinition of medical systems in general. Far from static self-contained entities, this research demonstrates that medical systems are permeable and in fact interrelated in ways that are only beginning to be explored.

The section that follows will look closely at Tibetan medicine, a significant part of government-supported health care in Bhutan. This exploration will begin with a general overview of how Tibetan medicine is practiced in the larger context of Tibetan Buddhist communities, followed by its history and use in Bhutan.

A General History of Tibetan Medicine

Exploring Tibetan medicine in Bhutan first requires us to look at the history and practice of Tibetan medicine in general. The sections that follow will also outline the philosophical roots of Tibetan medicine, as well as Tibetan medical diagnostic theory and methodology. Tibetan medicine is a tradition Bhutan shares with other Tibetan cultural communities, the history of which can be traced back to the Buddha. The history of medicine in Tibet and subsequently in Bhutan is closely connected with the history of Buddhism. Scholars of Tibetan medicine (Rechung 1973; Meyer 1995) suggest that the historical Buddha Shakyamuni gave specific teachings on medicine, which were recorded in Sanskrit and became part of early Buddhist sacred texts. As the Buddha's teachings spread through India, Tibet, and Bhutan, so too did the medical texts, which were subsequently translated into Tibetan by Padmasambhava when he traveled to Tibet. It is said that certain 'enlightened' rulers in Tibet began promoting the development of this healing knowledge, as it had been passed down from the Buddha (Rechung 1973). To this end, a meeting was organized to which great healers were invited, not only from Tibet and surrounding Himalayan countries, but also from India, China, and the Muslim world (RGB 2005, 5). The first International Seminar on Tibetan medicine took place in 700 AD in Tibet. It is recorded that during this meeting each of the different medical traditions were presented and examined by all who attended, and the best practices were adopted and incorporated from each tradition by the Tibetans (Rechung 1973, 17). In particular, Tibetan medicine embraced practices from Indian medicine and from Chinese medicine, and in fact, Elisabeth Finckh, a scholar of Tibetan medicine, suggests that in order to fully understand Tibetan medicine it is necessary to study Chinese and Indian medicine (1988, 9). What emerged from this historic meeting was called *gSo-ba Rig-pa* meaning "the knowledge of healing". The Venerable Rechung Rinpoche asserts that there is no distinction between the earliest recorded forms of Tibetan medicine and the form practiced today. Tibetan medicine practiced in Bhutan, therefore has an historical and philosophical continuity that can be traced back to the Buddha Gautama Siddhartha; knowledge of medicine and healing that has been passed in an unbroken line from physicians to students and so on through time.

Tibetan Medical Theory

"In the Tibetan system we believe that whether we are physically healthy or not, basically all of us are sick" (Donden 1986, 15).

Tibetan medicine is a complex system of healing and an area of study that goes beyond the scope of this paper, but in what follows I will briefly describe Tibetan medical theory. For Tibetan Buddhists, ignorance is the primary cause of suffering and illness. As Dr. Yeshi Donden, a Tibetan physician explains, in the Buddhist sense of the word, ignorance "refers to a state of mind that not only is not aware of how things actually exist, but also misconceives the nature of phenomena" (1986, 16). Tibetan medicine divides the causes of disease into two categories, long-term causes and immediate causes. Ignorance is a long-term cause of disease, one that requires Buddhist practice, perhaps over many thousands of lifetimes. Dr. Donden describes the relationship between ignorance and illness further, explaining that, "even if we think that there is no reason to be ill, even if we think that we are in very good health, actually we have had the basic cause of illness since beginningless time" (1986, 26). In turn, ignorance causes "afflictive emotions" (Donden 1986,. 16) like anger, greed, and desire.

But ultimately it is not the emotions themselves that are harmful but how we relate to those emotions. The emotions themselves are neither bad nor good unless we invest energy in them, in which case we are investing in the ego, a concept of self, which is completely illusory. The investment of energy in negative emotions in turn causes us to act on those emotions in harmful ways; this is the law of cause and affect, the law of karma. Ultimately, fueling negative emotion can lead to an accumulation of negative karma, which given the right conditions will manifest as specific diseases in this life or the next (Donden 1986,16). Tibetan Buddhists in Bhutan, and in other Tibetan communities, are embedded in a culture where ignorance and karma are central to concepts of health and causality with regard to illness.

In Tibetan medicine, three states of mind in particular are referred to as 'the three poisons'. They are: desire, hatred, and delusion. These cause imbalances within the humors or energies in the body. The three energies are Air (rLung), Bile (Tripa), and, Phlegm (Badken). In a more immediate sense, health is a balance between these three humors. The Tibetan humoral system is complex, affecting an individual not only on the physical level, but also on a psychological and spiritual level. Each humor is independent within the body but also interconnected. Each one of the three poisons corresponds to a humor. For example, Air overdevelops in the body in direct relation to an increase in desire. Bile overdevelops when anger cannot be pacified, and there is an imbalance in Phlegm when an individual becomes particularly close-minded (Dorjee 2005,148). The relationship between states of mind and the humoral/energetic system in the body is indicative of the mind-body connection in the Tibetan medical model. In a discussion on the role of the body in Tantric practice, Samuel points out that the connection between body and mind is explicit within the Tibetan Buddhist tradition (1989, 202). The Tibetan conceptualization of body and mind is completely non-dualistic. *Prana* or energy currents within the body are directed through meditation and Tantric practices. As Samuel states, "The mind rides on the currents of *prana*; where the mind goes, *prana* goes" (1989, 202).

While maintaining emotional stability is crucial to one's physical health, humoral imbalance can also be caused by more immediate factors like seasonal changes, diet, behavioural habits, and psychological traits (Dorjee 2005,130). Less mundane factors may also lead to an imbalance, including, as we have seen, karma, astrological changes, and spirits. Treatment can involve several approaches. So-called "superficial disorders" (Donden 1986,16) can be helped by changing one's diet and behaviour, or by taking medicine. Other disorders, like those with karmic origins, or those caused by spirits, may require the assistance of an experienced Tantric practitioner. The Tibetan system of healing is comprehensive and covers all areas of health and well-being.

Like other aspects of Buddhist culture in Bhutan, there is a vibrant visual element to Tibetan medicine. The entire system of medicine is represented symbolically as three trees with many branches and roots. The trees depict different branches of the Tibetan system including physiology, causation, diagnosis, and treatment. Bhutanese outline eight branches of traditional medicine: The body, pediatrics, gynecology, wounds and injury, toxicology, disorders caused by evil spirits, rejuvenation, and aphrodisiacs. The diagnosis of illness is a subtle and complex practice, which takes many years of training to master. Students study and memorize the Four Tantras, the primary medical texts. The Four Tantras are thought to have come from the Medicine Buddha in the form of the historical Buddha Shakyamuni. The Medicine Buddha is a powerful Buddhist symbol of healing and well-being and is always depicted seated in a full-lotus position. His body is a deep lapis lazuli blue, the colour of a stone that is believed to have special healing properties. In his right hand he holds a plant called Terminalia Chebula, which is renowned for its healing properties, while in his left hand there is a begging bowl full of medicinal nectar and fruit, also referred to as ambrosia, the elixir of immortality (RGB 2005, 8). The Blue Buddha is a stunning example of Tibetan Buddhist visual culture, depicting an other-worldly universe removed from everyday experience, conveying healing, well-being, and knowledge.

Tibetan diagnostic methods are an art form. The first and most important method involves taking a patient's pulse. This is done using the middle three fingers. Pulse reading is a subtle and skilled form of diagnosis and involves much more than simply feeling the beat of a patient's heart. Different parts of the physician's fingers correspond to organs within the body and also to the three humors. Dr. Yeshi Donden refers to pulse reading as "supreme among methods of diagnosis" (1986, 75). Another important aspect of diagnosis is questioning and observing the patient. This is an in depth process whereby the doctor allows the patient to first describe the illness or bodily sensation. The physician then questions the patient about behviour, diet, changes in weather, or any other factor that may affect the patient's health. The two final modes of diagnosis include urine analysis and tongue examination. Treatment is also multi-faceted and may involve medicine, meditation, the recitation of mantras or prayers, as well as other recommendations like a change of diet or increased exercise, depending on the diagnosis. However, as Dr. Pema Dorjee highlights, the most important aspect of healing is the relationship between the healer and the patient. The physician can affect the prognosis of any disease through the nature of his or her own being (Dorjee 2005,130). Thus the physician's personal level of spiritual realization is invaluable in the work of healing. The next section looks specifically at the introduction and evolution of Tibetan medicine in Bhutan.

Tibetan Medicine in the Bhutanese Context

Although the origins and history of Buddhism and medicine in Bhutan are similar to that of Tibet, Bhutan's unique cultural and environmental context has shaped religion and medicine as it is practiced in that country today, making it distinctively Bhutanese (RGB 2005, 6). The country's unique environment has been particularly influential in shaping pharmacological aspects of Tibetan medicine; the country has a rich and diverse flora and fauna, some of which is found nowhere else in the world. Appropriately, Bhutan has been called Menjong Gyalkhab, 'land of medicinal plants' for centuries. In addition, Tibetan medicine has been heavily influenced by locally held beliefs about deities, demons, and spirits.

Although Tibetan medicine has been present in Bhutan since the seventh century, it was not until sometime after 1616 that Shabdrung Ngawang Namgyal permanently established it in the country. It was under the direction of Tenzing Drukda, the Shabdrung's Minister of Religion, who was also an esteemed physician, that *gSo-ba Rig-pa* was established and spread throughout the country. From that time on, very little is known about traditional doctors practicing in Bhutan. The few that are known were trained in Tibet, a fact that confirms the strong connection between the two societies. There were personal physicians in the court of the first king and the successive rulers.

Traditionally, most practitioners of Tibetan medicine were monks, however there were other doctors who learned their skills from family members such that it became a hereditary profession, generally passed from father to son. Many well-known Tibetan physicians are reincarnations of great doctors from the past, their skills and knowledge reemerging in another individual after their death. Today Tibetan medicine is a tradition that is practiced by those inside the monastic community as well as those outside it. Physicians who practice outside of the monastic community do so at the institutional level, under the direction of the Ministry of Health, and also as independent doctors outside the purview of the National Institute of Traditional Medicine.

The practice of gSo-ba-rig-pa was formally included in the national health care system, and recognized as an official traditional medical system by the Royal Government of Bhutan in 1967. The Indigenous Dispensary opened on June 28, 1968 in Thimphu. The government employed traditional physicians to identify medicinal plants, locate collection sites, formulate medicines, and to establish links with traditional doctors in India, so that essential ingredients not available in Bhutan could be found. In 1971, formal training for physicians and pharmacists was initiated, a move that formally professionalized the traditional medical system by creating standards for the education and training of Tibetan medical doctors. According to some sources (Dorji and Morisco, 1989), while the use of other practitioners like exorcists, diviners, and practitioners of black magic are decreasing, the officially funded traditional medical system is increasing in popularity and use.

In 1979, the dispensary was placed within the new and much larger National Traditional Medicine Hospital (NTMH). NTMH launched a pharmaceutical production unit in 1982, and in 1998 the more formally organized Pharmaceutical Unit was established with the assistance of the European Commission. In 1998 the whole organization was renamed the Institute of Traditional Medicine Services (ITMS). Today the Traditional Medicine Hospital operates in a complementary, rather than competitive capacity with the biomedical sector; both fall under the direction of the Ministry of Health. The complementary relationship is aided by the fact that medical care in Bhutan, including biomedicine and traditional medicine, is free of charge. Whether this cooperative relationship will change as Bhutan shifts some of the costs associated with the health care system onto clients is a question for future research.

Traditional Tibetan medicine in Bhutan has gone through many changes over the years, not the least of which has been the introduction of a mechanized manufacturing process for Tibetan pharmaceuticals. This has separated the pharmacological component of Tibetan medicine from the practice as a whole, and changed the skill set of Tibetan doctors working at the Traditional Medicine Hospital. But as Dr. Yeshi Donden points out, "In Tibetan medicine, physicians and pharmacologists are not separate persons. A doctor must know all aspects of medicine" (1986, 22). Traditional physicians evaluated the quality and purity of drugs by means of smell and taste. Taste was used as an indicator to determine the composition, properties, actions, and ingredients of traditional medicines (Dorji and Morisco 1989). Today, traditional methods of production have been mechanized. A rigorous system of quality control is now in place at the Traditional Hospital to test every batch of raw materials, as well as the finished product. This is part of an ongoing quality control process designed to promote the standardization of traditional Tibetan medicines. The hope is to supply international markets with medicines grown and manufactured in Bhutan. Some of these products are already available for purchase online through the National Traditional Medicine Institute website.

Generally speaking, the policy of the National Traditional Medicine Hospital is to provide alternative medical care. The continued development and further integration of traditional medicine into the health care system has become a part of national policy; one that seeks not only to preserve Bhutan's cultural heritage, but also reduce the costs associated with a system that is free of charge. The government's approach is outlined in "Bhutan 2020: A Vision for Peace, Prosperity and Happiness":

> We must continue to provide a place for traditional medicine in our system of health care. Traditional medicine embodies knowledge that has been accumulated over centuries and which draws upon the nation's rich bio-diversity and of plants with proven medical qualities. As these qualities become substantiated by scientific research, there is a growing need to integrate more effectively traditional medicine with the modern system of health care. (RGB 1999)

When I interviewed Dorji Wangchuck, the Director of ITMS, he also spoke of the need to further integrate the biomedical and traditional sectors, a plan that would, in his view, improve patient care and cut back on health care spending in general. Moreover he expressed that in his view, the biggest cost to the health care system was patient referral outside the country; by improving patient service in both traditional and biomedical spheres inside the country, fewer patients would ask for outside referrals. The question of how to further integrate the two traditions is ongoing, and will no doubt continue as Bhutan's traditional health care sector develops.

At present, the Institute of Traditional Medicine Services (ITMS) has three departments: the National Traditional Medicine Hospital (NTMH), the National Institute of Traditional Medicine (NITM), where traditional doctors, pharmacists, and technicians receive their training, and the Pharmaceutical Research Unit. The National Institute of Traditional Medicine became a part of the Royal University of Bhutan at the end of 2004. The training programs vary from three years for a traditional pharmacist to five years for a physician. The Institute of Traditional Medicine Services has established indigenous units in all 20 Dzongkhags (districts) where premises are shared either with a district hospital or a Basic Health Unit.

The third department consisting of the Pharmaceutical and Research Unit is further subdivided into the Production Section and the Research and Quality Control Section. The Production section is where raw materials are put through an extensive process of quarantine, processing, and packaging. This is the only manufacturing plant in Bhutan, which makes it the sole supplier of traditional medicines for the entire country. Research and Quality Control is responsible for testing all medicinal compounds for safety and efficacy. This unit is growing in importance as the Bhutanese government and the National Institute of Traditional Medicine are increasingly interested in marketing medicines to clients and patients inside the country, and internationally.

The existence of a strong Tibetan medical system in Bhutan is due to many factors including the country's freedom from colonial rule. Independence has allowed the government to encourage and support Tibetan Buddhist culture free from outside interference. The uniqueness of this country can only be fully appreciated by noting the status of Tibetan medicine in other regions of the world, where it was once practiced freely. Tibet and Siberia are two places where Tibetan Buddhist culture and medicine have been marginalized. Siberia, for example was once a stronghold of Tibetan Buddhism. During the communist revolution, monasteries were destroyed and monks sent to work camps. Today there are virtually no training facilities for Tibetan medicine and very few practicing physicians. China is another example where the government has gone to considerable effort to divide Tibetan medicine into sacred and secular components. Although Tibetan medicine receives state support from the Chinese government, political and social conditions have made the 'scientific' aspects of Tibetan medicine safe while the religious aspects have been made politically unsafe (Adams 2001, 543). Vincanne Adams' research in the Tibet Autonomous Region has demonstrated that so called sacred or religious aspects of Tibetan medicine have become secret because of the fear of persecution by the Chinese government. But even in Bhutan where culture change has not taken place under such extreme duress, I believe that conceptual categories like religion and science, sacred and secular will be introduced as the country implements Western scientific standards and measurements to the practice of Tibetan medicine. In many instances, however, biomedical methods and standards are not incompatible with Tibetan medical theory and practice. Tibetan medicine is a rigorous medical tradition with its own unique philosophy and methodology, but as with other countries, development and modernization will change Bhutanese concepts of health and healing.

The Traditional Medicine Hospital

In Thimphu, getting from one place to another often requires that you walk uphill. The Traditional Medicine Hospital, alternatively known as the

Indigenous Hospital, is no exception. From where I was staying in Thimphu, the hospital was a short, yet at times strenuous walk uphill; the higher elevation in Thimphu was always challenging. Unlike the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH), which is more centrally located in the centre of Thimphu, the Indigenous Hospital is removed from the busyness of town in what is a more secluded and quiet location. Although health care policy in Bhutan indicates that Tibetan medicine and biomedicine cooperate in an integrated system, the two facilities are located at opposite ends of town. In fact, the Ministry of Health wanted to further integrate the two sectors by having the Indigenous Hospital and JDWNRH occupy the same premises. The plan was to house them both in a new facility currently being built with the assistance of the Indian government, however JDWNRH had an overwhelming need for more space and the plan has been shelved until some future date. Ideally, this would allow the two sectors to cross-refer more efficiently.

The Indigenous hospital is the largest traditional treatment facility in Bhutan. The hospital currently employs seventy-five staff members and eight doctors trained in Tibetan medicine. The Traditional Hospital provides traditional medical services, including herbal and steam baths, blood-letting, moxabustion (a form of heat therapy using acupuncture points), acupressure with gold and silver needles, massage, nasal irrigation, and medication. In addition to these treatments, traditional doctors are trained to give advice concerning Buddhist practice for illnesses that are karmic in origin. They also offer advice with regard to diet and lifestyle. Treating an illness involves bringing balance to the entire person, including spiritual, physical, and psychological aspects. All practitioners at the Indigenous Hospital are trained to give spiritual advice; and as the Director of the Traditional Hospital told me, in this capacity they fulfill a role comparable to a novice lama. According to the Director, all of the physicians are themselves Buddhist practitioners, reflecting that in Tibetan medicine, the doctor is an important conduit through which the patient may achieve well-being. Conversely, for traditional Tibetan doctors, treating patients can also be to their benefit because it can assist in their own spiritual development by compassionately caring for others. Tibetan medical practice and treatment is a two-way exchange highlighting the importance of the patient-healer relationship, a phenomenon that also appears to impact how biomedical physicians interact with their patients. For example, one physician I interviewed at JDWNRH reported that patients have expectations concerning diagnostic behaviour. Patients want to be touched, which includes having their pulse taken using the three-fingered method, a method that is specific to Tibetan medicine. They also expect a lengthy interview concerning their past and current health history, a technique that is also part of Tibetan diagnostic method. The doctor reported that when patients do not receive this kind of care they often express disappointment. Thus, the patient-healer relationship in Tibetan medicine has influenced biomedical practice in some intriguing ways.

The Indigenous Hospital in Thimphu is comprised of several buildings that have been constructed in traditional Bhutanese style. Architecturally, they are similar to traditional houses; they have ornately carved, and colorfully painted wooden-framed doors and windows; rooftops are also in traditional style and are raised above the top floor of the building. The government has sought to maintain the integrity of Tibetan Buddhist culture by legislating building styles that are traditional. Diagnosis and treatment take place in two buildings, which are placed in such a way, along with a third building, to form a sheltered inner courtyard. The third building, houses the traditional medicine museum and exhibits Tibetan medicinal herbs, and animal and mineral ingredients used in medicinal compounds. The museum also exhibits traditional instruments, some of which are no longer used at the hospital, as well as Tibetan diagnostic charts. The museum is a tourist attraction and is often on the list of sights that tourists can visit in Thimphu. Also located within this group of buildings is the dispensary, where patients pick up their prescriptions. Placed just in front of the dispensary are two large prayer wheels with benches placed on either side. The location and surroundings of the Indigenous Hospital are quite peaceful, the silence interrupted only by the bells that ring inside the turning prayer wheels. Prayer wheels are inscribed with mantras, most often that of Avalokiteshvara, the Buddhist embodiment of compassion. Turning the wheel sends the mantra into the universe, accumulating merit for the benefit of the sender and for others. The presence of the prayer wheel at the Indigenous Hospital is not unusual; they are commonly found at locations in and around Thimphu, and throughout Bhutan, especially places that have religious significance like temples and chortens. There are many types of prayer wheels including those that are hand-held, large wheels, like those at the Traditional Hospital, and water wheels, which are often located at water sources in the countryside.

The building where I conducted most of my observations contained several small rooms for consultation, treatment, and testing. A small hallway served as a waiting room where chairs had been placed against the wall for patients to wait; the entire space in this particular building was about the size of a large house. There was generally a mixture of patients, both young and old who visited the hospital. However, according to the Ministry of Health, the traditional sector is most popular with the elderly. The elderly account for 20-30% of out patient department visits at traditional units in district hospitals each day.

There are three rooms where steam treatments take place. Steam treatments are taken for chronic ailments like arthritis, for healing, for example following surgery or traumatic injury, or for general health purposes. I observed patients receiving steam treatments on many different occasions. During my time at the Traditional Hospital I was always accompanied by my counterpart, and was unexpectedly invited to move freely from room to room while treatments were taking place. This was done with the same casualness with which I was able to view most of the treatment facilities in the JDWNRH. There appeared to be specific ideas about privacy and personal space, in the sense that there did not seem to be a well-defined separation between public and private spaces. This was the case in other areas of Bhutanese life as well. For instance, in traditional Bhutanese homes, there is typically a large family room where many different activities take place, including food preparation, eating, sleeping, bathing, especially for children, and socializing with family and friends. From my perspective, I was uncomfortable with entering treatment rooms without permission from patients, however my counterpart, along with staff at both facilities, would often open treatment room doors and invite me to observe or speak with patients. As I shall describe in a later chapter on biomedicine, medical treatment at JDWNRH was a public, and even participatory experience for patients and family members.

Most of the treatment rooms at the Traditional Hospital do not have doors but are separated from the main room by a cloth partition. Steam treatment rooms take up much of the space in this particular building. In two of the rooms, steam is administered through a hose that is attached to a large container. Water is mixed with herbal compounds, which are heated and administered manually, usually by a patient or a family member. I observed that in many cases, at least one family member, and sometimes more than one, accompanied a patient to the Traditional Hospital. This was also true for JDWNR Hospital where I observed patients waiting in OPD with one or more family members. During one particular visit to the Indigenous Hospital, I observed a woman in her sixties receiving a steam treatment for her back. Her daughter administered the treatment, which also consisted of massage. Another treatment room contained a bathtub where patients could take an herbal bath. A third type of steam room is located in a small out-building. It is equipped with a bed, which is heated from beneath by steam mixed with an herbal compound. The patient lies on the bed wrapped in a blanket.

In addition to the steam rooms, there is also a room where gold and silver needle treatments are offered. This type of treatment is a form of acupressure whereby needles are heated and applied to pressure points on the patient's body. Table 1 below outlines traditional therapies offered at the Indigenous Hospital and the number of patients who used those therapies for three consecutive years.

Table 1. Number of patients for different therapies at the Traditional Hospital (RGB 2005):

Therapies	**2002**	**2003**	**2004**
Acupressure with gold needle	3603	3644	3618
Acupressure with silver needle	403	599	310
Blood letting	105	107	102
Herbal bath	1796	1796	2326
Steam bath	2295	2185	3197
Steam application	2851	2871	1296
Cupping	17	628	10
Nasal irrigation	183	22	202
Oil massage	411	418	314

There is also a consultation room where I was told "blood testing" takes place, however when I asked to observe this procedure, I was told by a physician that this would not be possible because observing the procedure could leave the patient vulnerable to attack by demons or bad spirits. I believe that in this case 'blood testing' meant blood-letting, a traditional medical practice. Due to problems with translation, I was not able to get a better explanation of why this might occur. This was the only time I was told that I could not observe a patient receiving treatment.

In terms of the types of conditions physicians at the Traditional Hospital treat, the Director reported to me that they typically see patients with chronic conditions, and that Tibetan medicines are taken on a long-term basis rather than for quick curative purposes. The Traditional Hospital specializes in treating conditions like sinusitis, arthritis, asthma, rheumatism, liver problems, and diseases related to the digestive and nervous system. Many of the patients I spoke with were seeking treatment for arthritis, which may explain why a large percentage of those treated at the hospital are elderly. In my interview with Dorji Wangchuck, the Director, I asked him whether the Traditional Hospital ever treated patients with acute illnesses. He responded that should a patient with an illness like cancer come to the hospital, they would be referred to a biomedical facility, usually JDWNRH. Ideally, according to the Director, this type of referral would also work in the reverse direction. There is no data as of yet as to how many patients are referred from JDWNRH to the Traditional Hospital or vice versa. After speaking with many in the biomedical sector however, my sense was that many doctors trained in biomedicine view traditional medicine with some suspicion. Although they may be willing to recommend a patient to the Traditional Hospital for complementary treatment, the general view from the biomedical perspective was that too many people use traditional medicine when they should go to one of the biomedical facilities. However, policy makers within the Ministry of Health appear to be quite committed to further integrating the traditional and biomedical health sectors so that they work in tandem. From my observations and interviews, people use traditional treatment without a referral from a biomedical doctor.

Typically, Tibetan treatments are used in conjunction with biomedical medication, following a biomedical procedure, or in some cases if other treatment options, including biomedical protocols have, in the patient's view, failed. In one case, I spoke with a woman who had sustained a large cut to the underside of her right thumb some weeks before. The woman brought her two-year old child with her and was also accompanied by her sister. The traditional doctor, a woman, attended the patient wearing a white coat, much like that of a biomedical physician or pharmacist. It is interesting to note that doctors at the Traditional Hospital wear clothing typical of the biomedical health care system. It is one indication of how the symbols of biomedical culture have been introduced to the practice of traditional medicine in Bhutan; it is also reminiscent of Margaret Lock's description of *kanpo* (herbal medicine) clinics in Japan, where she describes a young doctor wearing a white coat and a stethoscope protruding from his pocket (1980, 113). The woman received a steam treatment while the doctor sat behind her desk knitting; the whole scene was very informal. I asked the woman to tell me about what kind of treatment she had sought when she had initially cut herself, and why she was now receiving a traditional treatment for a wound that, from my perspective, had completely healed. She responded that when the injury occurred, she immediately went to the emergency room at JDWNRH where it was treated. From intake, she was directed to the appropriate specialist who ordered an x-ray. When I met her at the Traditional Hospital, the cut had healed, that is to the naked eye, but she said she was still feeling nerve pain, and that although she had returned to JDWNRH in the hopes that doctors there could offer her some further treatment for the pain, she was told there was nothing more they could do for her. She told me that this was when she decided to visit the Traditional Hospital. She was prescribed an herbal compound specific for bone and nerve damage, which was added to a steam treatment. I asked her about the treatment regimen; she responded that the herbal steam treatment is administered for fifteen minutes at a time, and that she could receive up to five treatments.

I also spoke with a Buddhist nun, Dechen, who expressed mixed feelings about treatments at the Traditional Hospital. I began by asking her about her health. She described an ongoing back problem that "bothers her persistently". Dechen had fallen going out to the toilet one night and experienced recurring back pain ever since. After the fall, she went to JDWNRH where, she says, they diagnosed her pain as a circulation problem. A physician gave her painkillers and also an injection of some sort. She explained that the medication took the pain away temporarily, but did not help the condition. She then decided to visit the Traditional Hospital where they told her that the pain was caused by cooling in her body and organs. She reported that she now receives physiotherapy at JDWNRH, which she finds quite helpful, and she also receives regular massage treatments at the Traditional Hospital.

Both accounts by patients at the Traditional Hospital illustrate the larger reality of Bhutan's health care system; that like medical systems in other countries, pluralism is the norm (Lock 1980; Leslie 1980; Stoner 1986). Individuals in Bhutan are familiar with multiple modes of medical thought and frequently seek out different types of treatments based on individual needs. In addition, the above cases illustrate that the biomedical healing experience is not always the most satisfying. Individuals may turn to traditional treatment when they perceive their needs have not been completely met by the biomedical option. I spoke with several individuals who expressed satisfaction with the curative power of biomedicine but described dissatisfaction with the way biomedical physicians treated them as a person. One individual went so far as to suggest that Bhutan should set up the first school for doctor sensitivity training because he such a negative experience while receiving treatment in the biomedical system. Certainly this is one reason why some individuals choose to seek treatment from the Traditional Hospital. As Margaret Lock points out, individuals in Japan often seek out traditional treatments because of their familiar symbolic content, because it contributes to 'healing' in a very powerful and holistic sense (1984, 132); the same can also be said of health seekers in Bhutan. Thus, the Traditional Hospital figures prominently into health care decision making for many Buddhists in the country. In the next section, I will describe the Pharmaceutical Unit.

The Pharmaceutical Unit

I was fortunate to tour the Pharmaceutical Unit on two occasions, where I observed the manufacturing of Tibetan medicinal compounds, a process that is not open to observation by the general public except by special arrangement. My interview with the Dorji Wangchuck, the Director of the ITMS provided much of the information found within this chapter concerning the collection and manufacturing of traditional medicines. In addition, I conducted a formal interview with Mr. Sonam Dorjee, a Research Officer at ITMS, who not only took time to explain the collection and manufacturing process but also permitted me to tour the manufacturing section.

Small scale mechanized production of traditional medicines began in 1982 with support from the World Health Organization (WHO). Up to that time, medicines had been produced by hand. The mechanization of traditional medicine and the separation of the collection process from the practice of medicine itself are two of the aspects that distinguish the institutional approach to traditional Tibetan medicine from those who practice outside the purview of the Ministry of Health. As I shall demonstrate, however, some Tibetan doctors still collect and make their own medicines. According to the Director of ITMS, the pharmaceutical unit produces 98 traditional medicines. Most of the pharmaceuticals are provided in either pill or powder form, although some syrups and ointments are also produced. The Pharmaceutical Unit currently produces about 5 metric tons of traditional medicines annually, which meets the needs of the whole country. The Pharmaceutical Unit also produces dozens of herbal products for the local market in Thimphu. The manufacturing unit has two drying centers located at collection sites where plant materials are dried and prepared. There is also a quality control area, a phytochemistry area, and a department where ethno-botanical plant samples are kept. Although most ingredients are plant based, other ingredients are mineral and animal based. Many Tibetan medicines are compounded and contain small amounts of plant, animal, and mineral materials.

About 85% of the materials used for medicines can be found within Bhutan while the remaining 15% are imported from India. The ingredients are collected mostly by villagers and sold to the hospital at a fair price, per kilogram, which is determined by the government. According to the ITMS Director, this allows individuals and communities to participate in the economy, and ensures the protection of Bhutan's traditional knowledge. Most people who do the collecting are rural Yak herding families whose only source of income is derived from Yak products. Thus, they are able to supplement their incomes by participation in the collection process. They are also encouraged to grow plants and herbs as a cash crop. The Ministry of Health along with the Ministry of Agriculture intends to promote the cultivation of more medicinal plants in the future; some are already grown in collaboration with the Medicinal and Aromatic Plants division of the Ministry of Agriculture.

Wild-crafted plants are washed and dried by the collectors on-site before they are brought to the Pharmaceutical Unit. Formerly, plants were dried outside, but according to Sonam Dorjee, this resulted in too much wastage when plants were washed away in the rains; many plants are collected in June, July, and August, the monsoon season in Bhutan. Today, drying is done at two locations, one for high altitude plants and one for low altitude plants. They are dried in large drying units run by electrical hydropower. Lingshi has been the collection and drying center for high altitude plants since 1967. To reach some of these collection areas it is a 4 to 5 day walk. Thus the collection and preservation of medicinal plants is crucial, not only for the sustainable harvesting of the plants themselves, but also for the continued economic benefit of those who collect them.

Bhutan is home to a rich variety of plant species found nowhere else in the world. Forests in Bhutan contain over 7000 species of plants. Bhutan is geographically diverse, which means that different areas are vastly different in terms of climate and vegetation. The country has a tropical climate in the south near the Indian border, and glaciated areas in the high northern regions where there is little vegetation. In between these two extremes are vast tracts of temperate and sub-tropical forest. Driving from west to east, you notice that this middle zone is made of many different microclimates. Small changes in elevation and moisture alter the type of flora and fauna found in these areas. Many of the plants needed for medicinal compounds grow at high altitude, and most are collected during the summer months when the mountain passes are largely free of snow. Teams from the ITMS are sent out on month-long field trips to oversee the collection process. Collection is an arduous job, as collectors must travel high into the mountains, sometimes as high as 5000 meters, to harvest plants that are found in small quantities. ITMS has identified more than 600 medicinal plants; practitioners in rural areas commonly use at least 300 of these. This is fact worth noting, because although Tibetan physicians at the Traditional Hospital no longer collect or process their own supply of medical plants, there are still many Tibetan medical doctors and other traditional practitioners who continue to procure their own materials. I met one such Tibetan doctor on my return trip from Ura in central Bhutan, and I will describe my interview with him in more detail in the following in the next section.

Visiting the manufacturing section at the Pharmaceutical Unit was, like many other aspects of Bhutanese culture, a full sensory experience. Upon first entering the facility, it was the smell I noticed first. I attempted to identify different ingredients by their smell, however it was next to impossible to discern separate ingredients. The closest way to describe the smell is to imagine the smell of nutmeg times ten; the scent was sweet, spicy, and incredibly strong.

Active ingredients are extracted from plant, animal, and mineral sources and are mixed according to precise guidelines. The powdered compound is then made into capsules and tablets; the whole process is mechanized. Tablets are taken to drying rooms and distributed on trays. Inside the drying rooms there are between 20 and 30 different kinds of tablets, each of a slightly different colour. The tablets are dried at a very specific temperature so they do not crumble.

One traditional medicine unique to Bhutan and worthy of a special note is the cordycep. Cordyceps are derived from high altitude caterpillars. A fungus infects the caterpillar, which then dies as the fungus consumes its body. The cordycep may be found by locating the fungus, which sprouts from the caterpillar's head and can be seen above ground. Gory though the details may be, cordyceps are a precious commodity for those who collect them, and for the country's economy. Compounds within the cordycep are believed to have regenerative anti-aging properties, and it is most highly prized as an aphrodisiac. According to Sonam Dorjee, during the SARS epidemic the price of cordyceps went up dramatically because of its reported strong anti-viral properties. The pharmaceutical Unit has manufactured a commercial product from cordyceps called 'CordyPLUS'. It may be purchased online through the Institute for Traditional Medicine Services (ITMS) website, along with other domestic products like herbal tea, herbal bath mixtures, and incense for Buddhist ceremonies. Cordyceps are an important resource for the country because they are bought from locals, processed and sold internationally to countries like China, Singapore, and the United States. Thus cordycepts are a valuable cash crop for Bhutan. In the Singapore, for example one kilogram can be sold for between $ 3000-4000 US. Cordyceps can only be found in the wild; attempts by the Chinese to grow them in a controlled environment have failed because the caterpillar that serves as the host for the fungus cannot be successfully transplanted from its high altitude home.

Thus Bhutan is seeking to carve out a niche for itself, as it has done in the tourist industry, by capitalizing on its uniqueness as a pristine environment where medicinal plants are not commercially cultivated but picked from the wild; I heard many people working with medicinal plants refer to them as 'organic' because they either wild-crafted or grown without pesticide. Globally, there is a growing demand for traditional remedies. A number of countries have begun conducting clinical trials to test the efficacy of traditional medicines, and to set out guidelines by which they can standardize, and in some cases patent traditional remedies. Bhutan's move toward the large-scale production and marketing of traditional medicine can also be examined within a larger context of other countries that are investing in the scientific investigation of traditional remedies. India for instance, has launched a new $40 million dollar project known as the 'Golden Triangle Partnership'; a partnership between the pharmaceutical industry and traditional systems of medicine like Ayurveda. With the help of Ayurvedic consultants, the pharmaceutical industry will identify and test traditional remedies for their effectiveness on a number of chronic ailments like arthritis and diabetes. Other such efforts are taking place in China and Japan where traditional medicine has been made available to the general public. More specifically however, interest in Tibetan Medicine is growing. The Tibetan Government in Exile under the direction of the Dalai Lama has established a healthy and growing network of clinics, teaching, and research facilities specifically for Tibetan Medicine. The Tibetan Medical and Astrological Institute, or Men-Tsee-Khang in Dharamsala, India also has a large-scale manufacturing unit in place for the production of traditional Tibetan medicines, and is beginning to conduct clinical trials using Tibetan remedies.

One such study, for example, is taking place at Mount Zion Cancer Centre in San Francisco, California. The University of California has partnered with Doctor Yeshi Dhonden, formerly the Dalai Lama's personal physician, to conduct a trial, using volunteers with advanced breast cancer. The trial not only uses traditional Tibetan remedies but also incorporates all of the diagnostic and treatment tools that Tibetan doctors have at their disposal. Doctor Dhonden prescribes the appropriate medicinal treatment based on urine analysis, taking the pulses of the patient and examining the tongue. Patients also receive dietary advice following a full Tibetan-based work-up of their current and past health status. Efforts to demonstrate the efficacy of Tibetan medicine in Bhutan are therefore part of a larger movement to bring attention to a centuries-old medical philosophy and methodology that may add to a growing number of health care options, like Chinese medicine and Ayurveda, used on a global transnational scale. Certainly as Tibetan medicine grows in popularity worldwide, it will be interesting to see if the large-scale production of Tibetan remedies for international markets alters the practice as a whole in Bhutan. In the next section I will describe a Tibetan doctor working outside the Traditional Hospital.

"If A Person's Mind is Spoiled, No Medicine in the World Can Fix It"

Pluralism characterizes the health care system at the institutional level; both biomedicine and Tibetan medicine are represented equally, however pluralism also describes Tibetan medicine. There are a variety of Tibetan practitioners but unfortunately there are no statistics on how many independent practitioners like Dorji offer their services to clients. Dorji, as I shall refer to him, is a Tibetan doctor working independently of the Ministry of Health. Dorji practices out of his home and is a skilled physician and pharmacologist with a deep connection to Buddhism. I spent two short days with Dorji, but in that time I learned a great deal about Tibetan medicine and about the lives of Bhutanese people.

Dorji lives in Jakar, a small, yet bustling town about half a days drive from Thimphu. I was invited to his home, made welcome and encouraged to ask him questions about his practice. Like many Bhutanese, he lives in a modest house made of sturdy wooden beams. There is no indoor toilet or washing facilities. Also like many Bhutanese, he lives with his family: two siblings, their children, and a grandmother. The family lives on the main floor of the house. The lower floor and the upper attic are used for storage; also typical of Bhutanese houses. One of the largest and best-kept rooms is the prayer room. Inside the prayer room, there is an ornately carved wooden altar that looks brand new. At the time of my visit, Dorji and his family were hosting a special ceremony for Guru Rinpoche. Forty to fifty people spent the day praying and chanting together in front of the altar; I was invited to participate with them. The day was an auspicious ritual day but also a social occasion. Tea, crackers and fruit were served to all the guests followed by a large meal that Dorji's sister had prepared for everyone.

I interviewed Dorji in his small kitchen, seated on the floor one evening after dinner. I asked him how he became a Tibetan doctor. He said that although he is no longer part of the monastic community, he began studying Tibetan medicine as a monk. He studied formally from the age of 18 until the age of 28, at which point he qualified to practice as a doctor. Dorji told me that his teacher's teacher studied traditional medicine in Tibet and that this made him part of an unbroken lineage that traces its origins back to the great Tibetan medical practitioners, and ultimately to the historical Buddha.

Dorji collects and makes his own medicines, skills that were learned as part of his training. According to Dorji, all knowledge of medicinal plants, the medicinal "recipes", as well as how to diagnose and treat illnesses are handed down directly from the Medicine Buddha. Dorji took out his considerable plant collection to show me. All the plants are dried and placed in large plastic bags for later use. To collect the plants he needs, Dorji hikes high into the mountains once a year where he carefully harvests precious ingredients. The whole trip takes one month.

He has compiled his own medicinal plant catalogue, which contains photographs of each plant. The entire catalogue consists of three small photo albums. I asked him how many patients he sees. He replied that at the peak of his practice he saw at least 50 patients a day, although today he no longer sees so many. I asked him to describe how he diagnoses his patients. He said that in order to ascertain the problem, the first question he asks is "how do you suffer"? Diagnosis includes a lengthy conversation with a patient to assess their current state of health, a process that addresses body and mind. To treat the patient, Dorji uses medicines first, but if they do not relieve the patient's suffering, he conducts a puja and consults the deities. Dorji was adamant that the spiritual elements of Tibetan medicine like puja are essential but that puja are always most effective when combined with medicines. This is a crucial point I will revisit later in this chapter. At the end of our interview, Dorji reflected that although Tibetan medicine is very effective, "if a person's mind is spoiled, no medicine in the world can fix it", indicating that for Buddhists, the ignorant mind is always the ultimate source of human suffering.

In the next section, I will describe the role of lamas and lopons in the health care system. Rather than separate and self-contained health care systems, Bhutan has a complex configuration of health care options whose boundaries are exceptionally permeable. Permeability between different modes of healing is particularly observable in Bhutan because many have Buddhism as their place of origin; this is true for Tibetan physicians and for healers like lamas and lopons, who not only share a philosophy of health and sickness, but in some instances diagnostic methods as well.

Lamas and Tantric Healing

When individuals and families make decisions about health care options, or anything else for that matter, it is customary to consult a lama or Rinpoche as they are often referred to, before making a choice. Lamas, therefore, occupy an important niche in the total health care system. The title Rinpoche literally means 'very precious', a term used for high status lamas or adept Tantric practitioners; however, such practitioners are not confined to the monastic system, and can be found practicing outside it as well. In Bhutan, as in Tibet, for example, there is a plurality of Tantric practitioners of varying abilities; these practitioners can be celibate or married. The word 'lama' essentially means 'teacher' and is equivalent to the Sanskrit term *guru* (Samuel 1993, 30). The terms lama, Rinpoche, and lopon (also meaning teacher) are used interchangeably, and generally refer to a relationship between an accomplished practitioner and a personal student or follower, rather than an office.

Nevertheless, there are many ways of becoming a lama. Some are born into lama families and inherit the lineage, which can date back many generations. I interviewed one young woman whose father was the fourteenth lama in a lama family. Others are reincarnate lamas or *trulku,* who have been recognized as the reincarnation of a previous lama. The best and most well known example of this is the Dalai Lama. Some lamas acquire their position by virtue of their spiritual development and mastery of Tantric practices, however in some instances the title can be acquired by virtue of an individual's skill as an administrator of an important monastic center. Some lamas acquire lama status simply because they are recognized as a lama by a group of people (Samuel 1993, 32). As Geoffrey Samuel observes, the fluidity and variability within the system is characteristic of Tibetan Buddhism (1993, 32). In other words, pluralism is characteristic of Tibetan Buddhism in general.

Tibetan Buddhists in Bhutan must negotiate a spiritual universe full of gods, spirits, and demons. The mediating force in this seemingly chaotic and unpredictable reality is the Tantric practitioner or lama. Thus, the role of the lama is similar to that of a shaman in traditional cultures around the world (Samuel 1993). Tantric techniques are used for the benefit of the community to contact and control spirits and deities but also as a technique, that if practiced intensively, can lead to Enlightenment within the present lifetime (Samuel 1993, 21). Tantric methods are believed to be the quick path to Enlightenment (Samuel 1993, 21). Various sects within Tibetan Buddhism place more or less emphasis on the use of Tantric techniques. As shaman-like practitioners, lamas enter deep meditative states in which they take on the identity of one or another deity, essentially becoming that deity. In so doing, the lama is able to combat negative forces like spirits and demons, and confer some of the power of the deity on to the community itself. For example, to assist a community with a malevolent spirit, a lama may take on the identity of Guru Rinpoche, an important historical figure who brought Buddhism to Bhutan, and tamed the indigenous deities, subjugating them to his power. By assuming the identity of the Guru Rinpoche, the lama can reassert his power over the offending deity (Samuel 1993,185). Samuel suggests that the aspect of Tantric practice, whereby a lama assumes the identity of a deity is, "… true whether the purpose of the ritual is… the attainment of Buddhahood, or some other goal such as the destruction of demonic forces or the achievement of good health and long life" (1993, 15). Powerful lamas contact a number of different deities including Tantric and local deities through visualization techniques. Contact with a deity can occur in two ways, the deity is either conjured as an entity outside of the lama, or the lama directly assumes the identity of the deity (Samuel 1993,13-21).

Deities can also appear to an accomplished lama in visions in order to give teachings or to help the practitioner achieve 'this-worldly' power; they can also help a practitioner to achieve the ultimate goal of every Buddhist, Enlightenment (Samuel 1993, 20).

For lay Buddhists, most Tantric practice is considered difficult and dangerous and is not to be undertaken without prolonged preparation, and only then under the guidance of an experienced teacher. This being said, there are a wide range of practices that are considered Tantric. For example, reciting the mantra "*om mani peme hung*", evokes the Tantric deity Avalokiteshvara, the embodiment of compassion. Reciting the mantra allows an individual to embody compassion him or herself; in this way, a lay practitioner may also directly communicate with a deity. Lay practitioners and lamas alike may practice this mantra and benefit from it. For most lay Buddhist, however, simply witnessing a Tantric ritual is in itself extremely meritorious (Samuel 1993, 260).

Many of the rituals performed by lamas, often accompanied by the monk body, confer long life and health upon members of the community (Samuel 1993, 262). Without long life and health, a Buddhist's opportunity to practice and gain further wisdom is curtailed; illness is an obstacle to practice. In this sense, the role of the lama is very similar to that of a Tibetan doctor; both remove 'obstacles', in the form of illnesses, which block the path to further Buddhist practice, and therefore to a quicker Enlightenment. Many of these rituals are referred to as empowerment ceremonies. In addition to conferring long life and well-being, individuals attend empowerment ceremonies to cure specific illnesses. Geoffrey Samuel cites an example from 1971, where on a trip to North India, he witnessed an empowerment ceremony conducted for a group of monks. He observed that many lay Tibetans also attended because it was rumored that the empowerment carried protection against cholera, which at that time was common in that area (1993, 260).

A family will often sponsor a well-known lama to perform a special blessing ritual. Rituals like these are expensive, which means that they are performed infrequently; but for those who can afford them, they guarantee karmic merit and well-being in the long and short term. Wealth is becoming more of a determinant of who can access such services. Karma Ura describes an emerging phenomenon in Bhutan whereby upwardly mobile Buddhists use their considerable resources to "buy merit" by sponsoring rituals, a practice, which in his words "renders Buddhists into a kind of commodity transaction in which those with material endowments will continue to dominate merit making" (Ura 2004, 17). Bhutanese society is historically hierarchical; wealthy landowners could buy more merit, so to speak by donating goods to local temples; however, increased access to monetary wealth has changed the practice of accumulating merit. Karma Ura suggests that buying merit is becoming individualistic rather than a compassionate act for the benefit of others (2004, 17). This may be one more example of culture change as the country begins to participate more in the global economy and contact with Western culture increases. The fear of moving toward a culture that reifies the individual is one reason why the government has continued to develop Gross National Happiness as an alternative to development policies that use economic growth and individual wealth accumulation as a measure of a country's success.

I attended a dinner with a family who sponsored an accomplished Tantric practitioner who was referred to as Rinpoche. In return for sponsoring the ritual, the Rinpoche conferred blessings on the house, the family, and a number of people also attending the dinner. Typical of many accomplished lamas, the Rinpoche was married; his wife also attended. Each family member and guest received a blessing from the Rinpoche. According to the family, the Rinpoche is well known for his psychic abilities and for making accurate predictions about the future. For example, the Rinpoche was asked to bless a sick child and make a prediction about her prognosis. In the context of health and healing, astrology and divination are part of a lama's skill set. Lamas are held in esteem for their predictive abilities, their ritual-ceremonial abilities, and their ability to 'empower' individuals toward health and well-being by conferring some of their power on to others.

While conducting my research on the health care system, I spoke with many individuals who had employed a lama to look for signs of illness or future misfortune. Lamas who are well known for their clairvoyant or divinatory abilities are called upon to determine the best course of action during an illness episode, or to suggest the best time to travel for treatment. As one individual explained to me, lamas have a clear way of seeing that allows them to make predictions about the outcome of a proposed course of action. Individuals and families may have one lama to which they are primarily devoted and therefore prefer to consult. But some health care seekers also ask for advice from more than one lama. The most common rituals performed by lamas, sometimes with the assistance of the monk body, are puja. Puja is a term that refers to religious ceremonies used for general cleansing and well-being. They can be performed to cleanse a household or for specific ailments. If you stay in Bhutan for any length of time, you become familiar with the cacophony of sound coming from neighborhood houses. Cymbals, trumpets, and drums always accompany the ceremony. Most households will conduct a large puja once a year to cleanse the house and ward off evil spirits that may have attached themselves to the home or to individuals within it.

Illness remains connected with the spirit realm; most illnesses in Bhutan are attributed to spirits or bad karma. These types of illnesses can only be diagnosed and treated by lamas or other Tantric practitioners. In fact, while diagnosing a patient, skilled lamas distinguish between illnesses that have a spiritual cause and those that have a natural or organic cause. Again, this is because of their reported "clear way of seeing"; they are able to perceive the karmic connections behind everyday reality (Samuel 1993, 371) and take the appropriate course of action. I interviewed a local practitioner who is well known for his diagnostic and healing abilities. His students and clients refer to him as 'lopon' or teacher. My counterpart describes him as a "great lopon" who can do many things, including disappear. Supernatural abilities are often associated with skilled Tantric practitioners. He is a monk by training, and also a teacher and practitioner. He consults with individuals who are ill and seeking treatment, but he also has a devoted following of students who he teaches Tantric techniques. For those who are ill, he diagnoses the ailment as spiritual or organic in nature, giving a recommendation as to the appropriate treatment. This particular lopon uses a number of diagnostic techniques, some of them similar to Tibetan doctors, to determine an individual's state of health. To better understand the diagnostic process, I submitted myself as a subject. The lopon checked my pulse on both wrists using the same three-fingered (the index, middle, and ring-finger) technique used in Tibetan medicine. He then questioned me thoroughly, again similar to the interview process used by Tibetan doctors to determine health history. The lopon then asked my age and birthday, at which point he consulted his astrological charts; astrology is an important aspect of Tibetan medicine as well. Astrological charts are used to determine the day on which specific parts of the body should not be treated. Bhutanese astrological charts are used to determine when it is auspicious to build a house, get married, or make a pilgrimage. Based on all of this information, the lopon made his diagnosis.

If an individual is suffering from an illness caused by a spirit, deity or witch, he performs a puja, involving the recitation of Tantric mantras. Many people consult him, including individuals who could not be helped by the biomedical system. For example, the lopon reported that a young man came to him suffering from, what the lopon described, as some type of wasting ailment. According to the lopon, the young man had lost weight and was becoming dangerously thin; he had been to the biomedical hospital and was told by doctors that there was not much hope for him, basically there was nothing they could do to help his condition. The lopon performed a puja and reported that the young man is now well.

Like other forms of traditional medicine in Bhutan, the lopon's services are complementary to biomedicine and are used in conjunction with biomedicine, rather than to its exclusion. When I asked the lopon what he thought of Western medicine he replied that "it is what it is", simply a part of the modern age. He asserted that the type of healing he provides is not a quick fix, not like modern medicine, which begins to work almost immediately, but is slower and takes more time to be effective. This coincides with information I received from many people about the difference between traditional healing methods and biomedical methods; traditional methods take effect more slowly while biomedicine offers immediate relief.

The case of a young woman with a life threatening form of cancer also illustrates how lamas are instrumental in health care. A close friend and caregiver reported her story to me in an interview I conducted with him. I will call the young woman Tsering. Tsering had been receiving biomedical treatment in India for quite some time but the outcome of her condition was uncertain. Believing that some spiritual intervention was needed, her friend called a Rinpoche on the telephone and asked him to make a prediction about her health. This particular Rinpoche, although from Bhutan, is now in the service of the Dalai Lama, which makes him an important and powerful person. Although the Rinpoche had never had any direct contact with Tsering, and although he was miles away, he predicted that the treatment she was now receiving would result in her recovery. After a couple of weeks, Tsering began to recover from her illness. During this time, friends and family conducted many puja on her behalf. Various people also donated money to a monastery and bought butter lamps for the monastic community. Monks at a well-known monastic center were also asked to perform a puja for her benefit. Another friend donated money to the Dalai Lama. This same individual suggested that he wanted to build a statue of the Buddha, a project that if completed, would generate great merit, and in his words "will keep good luck coming". Unlike at the Traditional Hospital, where services are free of charge, a donation is expected for healing or predictions performed by a lama. All of these activities ensure that if an individual's illness is karmic in origin, the compassionate act of giving will balance out the negative karma.

Individuals also consult with Rinpoches when deciding where to go for treatment. Many Bhutanese travel outside the country for health care because of a shortage of resources and expertise in Bhutan; in many instances the hospitals are not equipped for specialized treatment. There is a shortage of diagnostic technology like CT and MRI imaging equipment. When deciding where to go, an individual will consult with a lama, or sometimes two or three, before making a decision. I spoke with an individual who told me about a family member suffering from a burst appendix. In this instance, the man's wife chose to consult with three different lamas. She wanted to know whether she should take her husband to India or to JDWNRH in Thimphu, and which location would result in a successful recovery. The first lama she consulted told her to travel to India. A second told her to take him for treatment in Thimphu; and a third also told her to take him to India. Based on this advice, the woman decided to take her husband to India for treatment because, as it was expressed to me, "she had more faith in the first lama than the second or third". I was told, however, that had the individual traveled to India or Thimphu and died, instead of recovering successfully as the lamas had predicted, karma would have explained the negative outcome. For Tibetan Buddhists, any outcome can be explained by karma because there are incalculable unknown karmic strands, so to speak, that ripen and culminate in good health or poor health, as the case may be in a particular lifetime. In this instance, however, a successful recovery was his karma; the individual received treatment in India and survived.

As an explanatory model, the law of karma allows for a great deal of flexibility when assessing a person's state of health. Ordinary individuals cannot predict or understand the potential or cumulative effect of their own karma. Lamas, through their "clear way of seeing", are the interpreters of an individual's place in the karmic web. Lamas and Tantric practitioners are instrumental in the health care system, performing a number of services for their clientele; they make predictions concerning treatment, traditional or biomedical, and perform puja or healing ceremonies on behalf of the patient. They are mediators, intervening between patients and malign forces, thus contributing to the health of communities as well as individuals. The next section will explore the relationship between Tantric practitioners and the biomedical health care system.

Lamas, Health Care, and the Biomedical Community

In the previous section, I described Tantric practitioners and their role in the health care system. In many instances, they work in tandem with the biomedical health care system; individuals receiving treatment from biomedical doctors also employ lamas for healing and to predict treatment outcomes. Their influence extends far beyond what could be considered the religious or the sacred sphere of experience. From the perspective of practitioners like lamas, sacred healing and biomedicine function in a cooperative and complementary way. For instance, a lopon reported that some doctors in the biomedical system are very supportive of the use of spiritual healing in conjunction with biomedicine. In Bhutan people with different levels of education and economic backgrounds use a variety of practitioners and treatment options side-by-side. But there are some people in the general population and the biomedical community who are critical of using lamas as health care practitioners. Some biomedical practitioners, for instance, reported that some families visit lamas as primary care givers. The feeling was that individuals who use lamas for primary care were usually from more traditional or old-fashioned families, and that this type of health seeking behaviour was problematic because it was dangerous. One doctor told me about an experience he had, as evidence of the dangers of seeking health care from a lama. He reported that a child was brought to the hospital quite ill. The family had taken him to see a lama who had advised the parents against allowing the child to receive injections. According to the doctor, the staff at the hospital had to convince the parents to allow the child to receive intravenous fluids. The child received the fluids and as a result soon recovered. Many in the biomedical community would prefer that lamas refrain from giving medical advice and act as spiritual consultants only.

Stories about the dangers of seeking health care from lamas also circulate, at least in Thimphu, within the general population. They have, in a sense, become common knowledge. I observed that people who spoke negatively about using lamas for primary health care were often members of the middle and upper-class. It is difficult to determine whether a new class structure is emerging as a result of development, or whether it is consistent with an older structure where access to wealth was determined by land ownership. In any case, many of the people I spoke with who were critical of individuals using lamas for primary health care are upwardly mobile, well educated, and are observably less traditional than other Bhutanese. These same individuals also tend to be well traveled, in many instances receiving their post-secondary education abroad, and have therefore had more exposure to biomedicine in general.

In addition, in speaking with people, I can tentatively suggest that there is a generation gap in terms of who uses Tantric practitioners. Although lamas are very much a part of health seeking behaviour for the general population, it may be the elderly who are more inclined to use lamas as primary caregivers. From my observation, younger Bhutanese are more likely to seek treatment from biomedical doctors for primary health care, although they are by no means averse to seeking treatment from many different sources simultaneously, including lamas. More research is needed to better understand how lamas are enlisted as health practitioners, and how that use has changed over time.

Growing doubt about the safety of seeking health care from a lama or Tantric practitioner may also indicate a pattern of conflict emerging between different health care cultures. Such conflicts between the biomedical health care model and other differing models are, according to Kleinman (1980, 37), to be expected where a society is experiencing changes that accompany modernization. Some biomedical practitioners I spoke with expressed that they observed a substantial disconnect between biomedicine and its clientele. It was reported to me by more than one doctor that when prescribed medication, for example, people do not adhere to the instructions; in many instances self-medicating inappropriately. Another common complaint by those in the biomedical community was that people using the system often expect a quick fix for their medical problem. One doctor reported that patients "do not understand the cumulative nature of medication". Although biomedicine is a relatively new addition to Bhutan, its introduction has had a powerful influence on health care, and on how people think about health. Those who practice biomedicine are strong supporters of the scientific model of illness and disease. As Margaret Lock suggests, "the biomedical model…remains the most persuasive viewpoint for its many adherents" (1980, 10). But because biomedicine is a relatively recent introduction, health care is not the exclusive domain of biomedical theory and practice. Like other countries where pluralism is the norm, the boundaries between different medical traditions are much more permeable than anthropologists once thought. Health care is not the exclusive domain of the biomedical model. As Chencho Dorji, a psychiatrist and Buddhist pointed out, for Tibetan Buddhists, most illnesses are believed to have karmic origins; thus for many, biomedicine has little to offer except the treatment of symptoms. Lamas and Tantric practitioners continue to play an important role in the health care system; as Buddhist practitioners and healers, their knowledge and skills are derived from a philosophical tradition that emphasizes holism, an approach that addresses symptoms and the individual's relationship to the environment and to the cosmos. When I asked a lopon whether he thought the need for his services would diminish over time, he replied that the need for spiritual healing would never decrease. In the next section, I will focus on the biomedical system, describing biomedical health care in Bhutan's preeminent health care facility, Jigme Dorji Wangchuck National Referral Hospital, in Thimphu.

Biomedicine: Jigme Dorji Wangchuck National Referral Hospital

Named after the third king, Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) is the premier biomedical facility in Bhutan. JDWNRH is the largest and busiest hospital in Bhutan with approximately 200 beds, a large outpatient department, an emergency department, which includes an ambulance service, and an Intensive Care Unit. Other departments include the surgical department, dental, gynecology, ophthalmology, dermatology, radiology, anesthesiology, reproductive health, ear, nose and throat, physiotherapy, psychiatry, as well as laboratory services, and a pharmacy. The hospital also has a small number of private rooms, or 'cabins' as they are called, in which patients can stay for a fee. Unlike the wards, which are open, the cabins are self-contained private rooms. Except for certain dental services, most medical services, including medications are currently free of charge. These free of charge services also extend to the provision of specialized medical care for citizens who are referred outside the country for treatment. It is difficult to predict how much longer this will last considering the high cost of health care delivery and Bhutan's small economy.

The wards and the outpatient department are located in two separate buildings. To get to the wards from the Out Patient Department (OPD) you must walk uphill. The hospital itself is perched on a hill above Thimphu's main street and down the road from the National Memorial Chorten. As you walk from the National Memorial Chorten to the hospital, pedestrian and vehicle traffic steadily increases. The National Memorial Chorten, with its brightly colored Buddhist flags and golden-topped roof, sits on an island in the middle of the road, which is split to accommodate the structure. The Chorten is constantly buzzing with activity as people circumambulate it clockwise, always approaching it from the left as is customary. Walking past it you can just see the large Buddha statue peaking out of the window from its alcove on the Chorten's upper level. Traffic is also directed around the Chorten so that you must drive around it from the left;

it is like a large oddly shaped traffic circle. Taxis move back and forth from the hospital in a constant steam of coming and going. As you get closer to the hospital you can see on the right what will eventually be the new hospital. The construction site is dusty; the brown grey rubble surrounding the site sits in stark contrast to the green of the pine-covered mountains that rise up behind it. The new hospital site is next to the current JDWNRH. The Indian Government has provided a considerable amount of funding for the new hospital. It will contain 300-500 beds, 61 of which will be for an Intensive Care Unit. Forty-eight rooms are set aside as private rooms; many more than there are now. The new hospital facility will also house the newly acquired MRI and CT scanners, and a new oncology unit. It is still unknown as to whether some or all of the buildings in the current hospital will be demolished or incorporated into the new hospital complex.

Established in Bhutan in 1972, the National Referral Hospital is described as an "apex institution" (JDWNRH), meaning that it is the largest hospital and offers the most complete range of medical services in the country. The hospital serves a population of about 50,000 in the Thimphu area alone. This statistic, however, does not take into account referral cases from neighboring districts or from the 20 other districts in the country. It is for this reason that it is called a 'referral' hospital. In fact, personnel at the hospital expressed to me that the number of referrals coming to the hospital from other districts is far too high. Many cases are referred to JDWNRH because of a shortage of trained health care personnel and treatment services at the smaller district hospitals and BHUs. In many cases, patients who are in critical condition are sent long distances, sometimes bypassing the district hospitals, to the National Referral Hospital; unfortunately these patients are sometimes beyond help once they arrive. One pediatric doctor expressed frustration and dismay over what he perceived as a shortage of trained health care personnel who can make appropriate decisions as to the best course of action when he said, "We aren't given a chance to treat the patient". Currently, there are programs in place at JDWNRH to train health care personnel in rural areas in patient assessment and appropriate referral procedures. In some cases however, for example psychiatric services, treatment cannot be accessed anywhere but the National Referral Hospital at this time. Efforts are being made to expand psychiatric services to district hospitals and areas outside Thimphu. Psychiatric services are limited in Bhutan; when I was in the country in 2006 there were only two trained professionals working at the hospital, only one of which was an MD. Both are based in Thimphu at JDWNRH.

It is evident from the crowds of people waiting outside OPD everyday that the general population in Bhutan has embraced biomedical health care. Patients begin lining up outside OPD for treatment early in the morning. The hospital now has an electronic token system, which was introduced to decrease wait times and make the system more efficient in general. It is difficult to say whether it has, in fact, made a difference. Many of the people I spoke with were confused by the system and told me about lengthy wait times.

I spent most of my time in JDWNRH shadowing the physiotherapy staff, following them on their rounds, which for the most part included the Main Ward, the Orthopedic Ward and the OPD service attached to the Physiotherapy Department. The wards are divided into male and female sections. Curtained partitions can be erected around a patient's bed should the need arise. Patients and families can often be seen socializing or assisting one another. All the in-patient wards are generally very busy. I visited the orthopedic ward on numerous occasions and it was always full. Far from the exotic and peculiar, much of what I observed at JDWNRH was similar to what one might see in any North American hospital. What happens to bodies when they are diseased or injured is the same no matter where you are in the world. Spending a significant amount of time at JDWNRH meant becoming familiar with the sights, sounds, and smells associated with sickness, traumatic injury, and human suffering.

There appeared to be more men than women with serious trauma injuries. I have no point of comparison having never been in an orthopedic ward in Canada, so it is difficult for me to judge whether these types of injuries in these numbers are unusual. A Canadian physiotherapist working as a volunteer, and with over twenty years of experience, told me that she had never seen so many traumatic injuries. Moreover, many of the injuries were more complex than she had seen working in Canada. There are many spinal cord injuries, serious wounds to feet, hands, and several amputees. These injuries are often work related or the result of car accidents. Road conditions in Bhutan can be treacherous because the roads are only a car length in width and wind precariously along mountainsides that drop off steeply. It is all too common for drivers to go off the edge of a cliff while attempting to pass another vehicle. In an article entitle "Seat belt saves lives", Dr. Paul Moroz, a visiting orthopedic surgeon from the University of Ottawa remarks that the high number of major car crashes in Bhutan is such that "there are just not enough beds, surgeons, nurses, intensive care beds and equipment to adequately deal with all the severely injured" (Kuensel 2006b). There also appeared to be quite a high number of children and younger patients on the ward. Just to give a few examples, one young boy had severe chemical burns on his legs; another man had been in a car accident and was paralyzed from the waist down, and one child who appeared to be no more than two years old had severe head and facial burns, most likely from a cooking fire at home.

The wards themselves are clean and smell of a combination of antiseptic cleaner, alcohol, lemongrass oil, and incense. Lemongrass oil is made in Bhutan and has a strong lemon smell; it is commonly used as a cleaning agent and is also sold to tourists as a souvenir. Although the hospital is clean, the facilities are basic. There are no air-conditioning units and because it was summer, the wards were quite warm during the day. Patients and family members coped with the heat by opening windows, although this let in flies, which were an irritant, especially for stroke patients who were often unable to move.

It is common for patients to have pictures of Rinpoches, high lamas, or small amulets hanging next to their beds. In every ward there is a picture of the King and the Je Khenpo, the head of the dominant Drukpa Kagyu Buddhist sect.

There are also thangka (wall hangings) of the Medicine Buddha. In the nurses station just off the main ward there are two pictures hanging side-by-side; one is a biomedical illustration of the human skeletal system and the other is a colourful mandala surrounded by prominent figures in the Buddhist pantheon. In addition, the mandala has a white scarf draped around the frame. These scarves are typically blessed by a lama and are auspicious symbols. The placement of these paintings together is demonstrative of how the biomedical system has adapted to the Buddhist cultural context.

In addition to Buddhist symbols and paraphernalia, elements of traditional Bhutanese culture have been incorporated into the biomedical system. For example, nurses wear a slightly modified version of a kira, the traditional dress worn by Bhutanese women. The kira is a single piece of woven cloth that is wrapped and pinned using broaches at the shoulders. It covers a woman to her ankles and is worn with a blouse underneath. Typically a short jacket called a toego is worn over top, and the sleeves of the blouse are folded over the cuffs of the toego. The nurses' uniform consists of a white kira with a navy jacket. The only nurses in the hospital who do not wear traditional dress are those working in the pediatric ward. Unlike the other nursing staff, they wear green Western-style scrubs. Nurses are generally female, although there are men who work as physiotherapy assistants and health assistants on the wards. With the exception of visiting doctors volunteering at the hospital, all of the doctors are male. Some male doctors wear the traditional gho while others wear the recognizable Western style scrubs. The gho is the traditional dress worn by men, and like the kira, is a single piece of woven cloth. Unlike the kira, it has arms like a regular shirt. It is folded in the back and secured with a belt. It is typically worn on or just above the knee.

Much of the activity I observed in the hospital was what one would expect from health care in a biomedical facility. Doctors perform rounds and examine patients while nurses change dressings and administer medication. But there were aspects of care at JDWNRH that stood out from the day-to-day activity, and perhaps differ from what one might find in a hospital in the United States or Canada. For instance, the high level of family involvement in caring for a sick person may be another example of how biomedical practice has been altered by Bhutan's unique cultural context. Family members perform a significant amount of personal care for relatives staying in the hospital. This includes washing, helping the patient to the toilet, and changing and turning sick family members. On one occasion I was invited to visit a young woman suffering from an acute and debilitating form of lupus. She was unable to move or feed herself due to the disease. Her father and sister were taught how to feed her using a feeding tube, manually pouring the formula into the tube. On a number of occasions I observed the family members of one patient caring for another individual who was also on the ward. People often share food or just sit with one another even if they are not related. Patients socialize and help one another as well. Those with the most traumatic injuries or illnesses are often in the hospital for months and because the wards are open, people become familiar with one another very quickly. It is not unusual for family members to stay in the hospital, often sleeping in a chair or sometimes on the floor. The psychiatric ward is one example where family involvement is highly encouraged and supported. While conducting informal participant observation at the psychiatric ward, I observed that patients are generally admitted with an accompanying family member who is also accommodated within the ward. The psychiatric ward is organized so that family members can accompany the patient to the hospital and stay with them to assist in their treatment. Not only does this system support patient recovery, it is incredibly functional because family members learn about symptoms, medication, and dosage. In this way, family members are enlisted to help oversee patient aftercare as well. Dr. Chencho Dorji, the psychiatrist at the hospital, asserted that in this respect the in-patient program is as much for the patient's family as it is for the patient. Family involvement is seen as an essential part of a successful patient outcome and is, in essence, an extension of a cultural tradition in which ties to family and community are highly valued. In addition, observation of interactions between patients and the only psychiatrist in Bhutan reveal patient expectations that have been shaped by centuries of exposure to Tibetan medical practice and culture. Patients expect to be touched, have their pulse taken, and have a lengthy interview, all aspects of Tibetan diagnostic method. This is one more example of how biomedicine has been adapted to the Bhutanese context.

Some of the care given to patients by family members, especially once they leave the hospital, is out of necessity because very few patients receive follow-up care. Bhutan is in the process of developing its health care infrastructure, and in terms of biomedical material and equipment needs, there are many areas where the hospital would like to improve. For instance, families are required to provide bedding and meals for family members admitted to the hospital. Also, from the perspective of the physiotherapy staff, there is a need for basics like bandages and for equipment like wheelchairs and walkers. There is also a pressing need for additional human resources, especially in rural areas, where many patients are still hours from the nearest road, hospital, or BHU. However, based on my research, I believe that much of the care given to patients by family members is reflective of the cultural context. Individuals in the Buddhist culture in Bhutan are typically embedded in large family networks, and sick family members are cared for within the family unit. The elderly are cared for at home and children are raised within extended family network, often spending equal amounts of time with aunts, uncles, and cousins as they do with parents and siblings. In her examination of the East Asian medical system in Japan, Margaret Lock observes that the family unit has a shared responsibility when caring for a sick person (1980, 218), and that "the healing process is viewed, therefore, as something to be collectively participated in by the family members" (1980, 218). I found this to be the case in Bhutan as well where family members are intensively involved in the care of a sick individual, and in many instances expressed strong feelings about caring for family members at home. Mirroring the tendency for family involvement, the hospital gives extensive training on home care, including how to continue patient treatment and rehabilitation after the patient leaves the hospital.

Nevertheless, patients in Bhutan do fall through the cracks. Physiotherapists reported that the hospital often loses track of patients because there is no mechanism in place by which to conduct follow-up visits. Volunteer physiotherapists often visit patients in areas outside Thimphu because of a need for urgent care. In one instance, a young man, who was injured and became a paraplegic, was sent home without a wheelchair because one was not available. Staff members were hopeful that they could raise money for supplies to help support the young man at home. After an extensive stay in the hospital he was released and, according to the physiotherapist, he and his family "disappeared". Reportedly the young man was readmitted to JDWNRH months later to receive treatment for bedsores. He was released and "disappeared" again. The reality in Bhutan is that there are not enough resources for patients once they leave the hospital and follow-up is rarely possible.

In addition to socializing, patients are also very interested in one another's treatment. Often when I accompanied the physiotherapists on their rounds, the treatment given to one patient would attract an audience. There were times when family members and patients would not only observe but also offer advice concerning an individual's diagnosis and treatment. For example, I observed a consultation with a twenty three year old man who had suffered a stroke. Many people came to observe the consultation, including other patients and their family members. Many of them expressed concern for the young man and his recovery. Although the young man's condition was stable and he was medically ready to go home, the physiotherapist hoped to convince the family to allow the young man to remain in the hospital so that he could receive additional rehabilitation. Many who observed his consultation expressed concern that he was leaving too early and attempted to assist the physiotherapist to convince the man's family to allow him to stay. One middle aged gentleman, who I assumed was a doctor because of the authoritative way he was speaking to the young man's family, in fact turned out not to be a doctor but the son of the elderly woman two beds down. According to one physiotherapist, it is quite common for family members and patients to offer advice and show interest in one another's recovery. There seemed to be a strong sense of community on the wards where advice and assistance are given freely to one's own family member and to others as well. There is an interdependence expressed that appears to be a reflection of Buddhist values and of the communal nature of Bhutanese culture.

'Menchoy Rimdo'

Tantric healers like lamas and lopons are involved in discerning whether an illness has a spiritual or organic cause and then making the appropriate recommendation as to treatment. Depending on the diagnosis, they may perform a puja or suggest that a client see a biomedical doctor. As practitioners in the health care system, they are involved in the work of healing, helping to alleviate suffering. Thus, the lama's role and the importance given to the performance of religious ceremonies in health care are well established in Bhutan. Tibetan doctors perform a similar function with regard to health care. They offer a thorough diagnostic process, religious ceremonies, and Tibetan medicines carefully compounded from local ingredients. Biomedicine offers diagnostic procedures based on very different philosophical and methodological underpinnings, but its technology and pharmacology have been enthusiastically adopted by Tibetan Buddhists nonetheless. These differing models of health care come together and co-exist in a medical system that is pluralistic. Thus, it is the norm to employ more than one health care option when experiencing an illness. This reality is expressed in the use of a term that reflects Buddhist concepts of balance and holism on the one hand and pluralism on the other. In Bhutan, there is a phrase 'menchoy rimdo': 'menchoy' meaning treatment, and 'rimdo' meaning religious rites. Dr. Chencho Dorji explains menchoy rimdo this way: "Medical treatment and religious rituals like puja always go hand in hand". And further, the cause of an illness and the symptoms must both be addressed; the root cause to alleviate further occurrences of the illness and the symptoms to prevent further physical suffering. Again, for Buddhists the root cause of most illnesses is negative karma or dangerous spiritual entities, which can only be treated by cleansing rituals or blessings performed by lamas. According to Dr. Dorji 'menchoy' or the treatment of symptoms can include either traditional Tibetan medicine or biomedicine. Although firmly rooted in the Buddhist culture, menchoy rimdo as a concept has adapted to include the use of biomedicine as an option for the treatment of a disease state and the symptoms it presents. Ideally, both the spiritual cause of an illness and the disease state or symptoms that arise as a result are treated, an integrated and holistic approach to health and well-being. The interconnected nature of religion and healing became clearer when I learned about menchoy rimdo, a concept that aptly describes and embodies the unique way that Buddhists in Bhutan think about health, and the distinctive configuration of health care practitioners who are employed by health care seekers.

In the course of my research a pattern has emerged, which suggests that a majority of Buddhists in Bhutan use more than one form of treatment; and that during an illness episode it is likely that an individual will seek the services of a lama, while also using the biomedical or Tibetan health system for treatment. Interestingly, many individuals I interviewed made the distinction between "the religious side" of treatment like puja, and other treatment options like Tibetan medicine and biomedicine. The next section will look at this conceptualization from the perspective of a young upper-class Bhutanese woman, and will further elucidate the 'side-by-side use of multiple health care options.

Medical Pluralism in a Bhutanese Family

Bhutan is a country where many factors like class, ethnicity, religious affiliation, occupation, social networks, geography, altitude, and even climate influence how differing groups perceive and use the health care system. In addition to these social and environmental factors, available health care services are unevenly distributed throughout the country, especially in more remote rural areas, meaning that different communities may or may not have access to the types of health care services that are available in Thimphu. As Arthur Kleinman suggests, health care systems are functions of specific social realities, which can be viewed at the level of the community, the family group, or the individual (1980, 39). Thus, according to Kleinman, "multiple and divergent health care systems" (Kleinman 1980, 39) are created within these "local environments" (1980, 39). This section will explore the 'side-by-side' use of health care options in Thimphu from the perspective of a young Buddhist woman and her family. For this section, I have drawn from a formal interview I conducted with this young woman, who I will call Sonam. How she and her family view and use health care options in Thimphu is distinct, but is also reflective of a larger social and cultural reality in Bhutan; that is a shared Buddhist tradition and a health care system based on pluralism.

Sonam and her family are Tibetan Buddhists. Her father is part of a long line of lamas, as she says, "we come from a lama family". Sonam's father was the fourteenth lama until he suffered a severe stroke and the position passed to his half brother. The lama position is attached to a monastery located in Shingkar, a village in central Bhutan. Before the stroke, her father traveled to Shingkar, sometimes daily, to perform ceremonies and rituals. It was on one of these trips that her father suffered a stroke, and was driven fourteen hours back to Thimphu for treatment.

Sonam lives with her family in Thimphu. She resides with her mother and father, two brothers and one sister. Her brother and his family live in a separate home on the same property. Her sister also lives on the property in an apartment with her three children; Sonam's other brother works abroad for the United Nations. She also has an uncle who is a physician and works for the

World Health Organization. Sonam took two years of business administration in Bangkok, but chose to come back to Bhutan to help her family. She manages the family business, a set of apartments on the property, as well as a restaurant. Her family owns land in Shingkar, and because of their status as a lama family could be considered part of the upper-class. The high level of education in her family is also typical of many families in Bhutan who are upper-class. They are educated abroad and take up positions in government or with diplomatic organizations.

Like other developing countries, Bhutan is experiencing a population shift from rural to urban areas, especially from surrounding areas around Thimphu, the capital city. There are many factors influencing the depopulation of rural areas including, most significantly, the availability of employment. Thimphu sits at the heart of the country's tourist industry, which is growing exponentially as the government, with the help of wealthy foreign investors, continues to grow the sector. Unlike people in rural Bhutan, Thimphu residents have unhindered access to a variety of health care services, including the Traditional Hospital and the country's premiere biomedical facility, JDWNRH. The city is also the center of government, diplomatic, and royal activities, which means that many people living in Thimphu are attached in some way to government services or to His Royal Highness (HRH) and the royal family. As a result, there is a subset of the population in Thimphu of a higher socioeconomic status who can, if they choose, pay for private biomedical health care outside the country. Sonam's family is just such a family.

Like other Bhutanese families, Tibetan Buddhism is central to their experience of health and illness. Sonam, like other young Bhutanese, have embraced many aspects of modernization while still maintaining their traditional beliefs. Sonam describes herself as "not as strongly Buddhist as her parents and brothers", and that at times she has neglected to perform all the rituals necessary for the maintenance of local deities and spirits. However, she tells me that her experience of coping with an allergic reaction caused by a Naga spirit, has motivated her to tend to her ritual duties with more vigor. Like many Buddhists, Sonam is conscious of spirits and deities and the potential danger they pose to her health. In this way, Buddhist ritual and ceremony continues to be an important part of her life, and certainly that of her family.

Like other individuals I spoke with, Sonam and her family are very open to other forms of treatment and actively seek out and use multiple health care options in a complementary way. For Sonam and her family, 'menchoy rimdo' is part of a conceptual framework of health and illness that prescribes a dual approach to healing. In this regard, Sonam says, "Normally we do everything side-by-side". Religious rites and the treatment of symptoms always work best when administered together. Intriguingly, Sonam distinguishes between, what she describes as the "religious side" of medicine and healing, like puja and blessings, and non-religious treatments like biomedical medication, Tibetan medicine, and homeopathy.

On the "religious side", when an individual in the family becomes sick, Sonam and her family enlist the help of a lama. They are called upon to treat specific illnesses and for general health and well-being. But, lamas also prescribe medicine. This was an aspect of Tantric healing I was not aware of until I interviewed Sonam. Using Tantric prayers, lamas bless medicinal substances, imbuing them with healing properties. This is an intriguing aspect of healing in Tantric Buddhism that warrants further study.

Sonam describes one of these medicines, called demcey, in the following way:

> I forgot to say, then we have this, from the religious side we have this black thing that we call demcey…so we eat that. It's good for sore throat. We just soak it in hot water and just drink it. It's very sour and bitter. Actually it's all kind of roots and herbs. They mix it with a little bit of mud or something and dry it in the sun and make it into small, small pieces, like small little black things. That is from the religious side. When you [receive] blessings from a lama or something, they always give you a little bit. And also, actually when we have body aches and things like that, we have Vaseline or cream that we give to a Lama and [he] gives his blessing and he gives it back. We also use that because we believe that it helps with body aches and little sores.

Although I cannot say with certainty, demcey is probably similar to medicinal compounds made by Tibetan doctors. Like Tibetan medicines, demcey is a combination of various medicinal roots and herbs that are dried and given out in the form of small tablets. Geoffrey Samuel (1993, 262), referring to Beyer (1973, 373-398) describes "empowerment pills", which are given out by lamas during Tantric ceremonies to imbue participants with long life and good fortune; they also cleanse non-virtuous actions that affect karma. Similarly, in Tibetan medicine, medicinal compounds are considered to be just a mixture of ingredients, until they have had blessings specific to the Medicine Buddha recited over them. Only then is the mixture of ingredients considered a medicine. For this family too then, sickness is the result of a combination of factors that originate both inside and outside the individual, both karmic or spiritual, and organic in nature.

In the course of the interview, Sonam describes in more detail her father's condition. In the two years since his stroke, caring for him has become a large part of her life. I asked Sonam to explain what she thinks caused her father's stroke:

> Actually we had two things. We knew he had a stroke, but also we called up some big, high lamas in Sikkim and we asked him, because he normally does the dice and he tries to see what's wrong, so he was saying something to do with his [her father's] monastery, maybe it got dirty and maybe some bad people came in there and you know, things like that, which was not good for the monastery, so probably it affected him because he's connected to the monastery there.

Sonam's explanation for her father's sickness is twofold. On the one hand, she understands that on a purely physical level, he had a stroke; on the other hand, however, it may have been her father's connection to the family temple, which ultimately caused his illness. Good moral behaviour is considered very important in Buddhist societies and is directly connected to the law of karma. The term karma literally means "action" (Samuel 1993, 378). Each action, thought, or intention can affect what happens in the future. This is why many Tibetan Buddhist rituals are directed at cleansing an individual or home of negative karma or dangerous entity, which in a sense, sticks to an individual or a place, eventually culminating in a serious illness. For Sonam, some other person's lack of moral character affected her father's health. The effects of negative karma, including human action and thought, are illustrative of the interdependent nature of all phenomena.

Like the explanation for the sickness, the treatment is also twofold, addressing the symptoms and the root cause. For Sonam and her family, healing is a multi-faceted process involving several different modes of treatment. As our conversation progressed she confirmed the side-by-side nature of treatment:

> Because when my dad was sick also, when he was in Calcutta we were performing [religious] rites almost every day, rituals yes. Almost everyday we were having rituals at home then we had sent money to other monasteries so they could read some holy scriptures. But in our family, normally we do everything side-by-side. So if we have somebody getting sick in the family, we go to the hospital first. And with that we call up some high lama and ask them if they could roll the dice and find out what kind of rituals we have to do at home. So according to what the high lama says, according to that, we organize a ritual with the puja and the monks at home.

Today, treatment for Sonam's father includes a variety of therapies. He takes medication prescribed by a biomedical doctor and Tibetan medicine. According to Sonam, he also finds physiotherapy very helpful for his recovery. Sonam also told me that her father does not go to the outpatient physiotherapy department at JDWNRH. Instead, the physiotherapist comes to the house. I asked her why this is the case.

> Actually we used to go there but for spiritual reasons he didn't want to go there anymore. Because we believe that when there are people dying and people being born, there is some kind of thing that we can't see that sticks on to us and makes us sick.

For Tibetan Buddhists, there are always spiritual[1] considerations when deciding when and where to seek treatment.

Finally, when I asked Sonam if she thinks the growing popularity of biomedicine will be detrimental to traditional medicine, she responded, "I don't think it will because people will always come back. They like to try everything." This in essence encapsulates my findings concerning health care in Bhutan. Although Sonam and her family represent one case study, it reflects data I collected from many people who also use multiple health care options in a health care system based on pluralism. The following chapter is an ethnographic exploration of life and health care rural Bhutan and will focus on two villages, Ura and Shingkar.

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[1] Again, the use of a term like 'spiritual' does not adequately represent the seamless and interconnected nature of Buddhism with other spheres of experience like health and healing. As a conceptual category it is limited but even some Bhutanese like Sonam make a distinction between the "religious side" of medicine and other non-religious health care options.

Chapter 4

LIFE AND HEALTH IN RURAL BHUTAN

Ura is a unique local environment and for this reason I believe it warrants consideration separate from the data gathered in Thimphu. Ura is geographically, ecologically, and culturally distinct from other regions in Bhutan. I have included this data in a separate section for several reasons. First, it documents, in a preliminary way, health in a rural village setting, an area of research that has not been documented at all in the anthropological literature on Bhutan. The second reason for presenting the data separately is that it contributes to an ethnography of everyday life in the country. I was fortunate to travel to Ura, where I spent one week immersed in the daily rhythm of life. Moreover, I chose not to integrate the data from Ura and Shingkar with that from Thimphu because I believe it is important to present it within the rich cultural and geographical context in which it was gathered. I have chosen to present some of the data in this section as small ethnographic vignettes. Presenting the data as individual cases preserves the 'flavour', so to speak, of the context in which they were collected. Each vignette represents a person, experience, or encounter and contains a wealth of information, not only about health and health care, but also about life in rural Bhutan in general.

In addition to the data on Ura, I collected data in Shingkar, a village in the same district, where by chance I met and interviewed a young man about his illness experience. These findings reveal that throughout Bhutan, the health care system is based on pluralism. I found much the same pattern of use in Ura and Shingkar as I did in Thimphu. I have also included some of my observations about the journey to Ura itself. While I spent only a week in Ura, the impressions of rural Bhutan and the people living there are particularly vivid and remain with me.

Ura: The Journey And The Setting

Ura is located in a district called Bumthang. In many ways Bumthang, and especially Ura, are considered the cultural and spiritual heartland of Bhutan. Bumthang is the general name given to four valleys: Chumey, Choekhor, Tang, and Ura valley. Ura valley is the highest in Bumthang; the village of Ura sits at about 3100 meters. Before unification under the Shabdrung, Ura was ruled by a line of petty kings and was settled by what are described as "strongmen" claiming Tibetan ancestry (Ardussi 2004, 1). Even before the arrival of the Shabdrung, Bumthang was the center of the Nyingmapa Buddhist sect. The Nyingmapa mainly ascribe to the teachings of the 8th century Indian saint Padmasambhava who established monasteries throughout the country, including one in Bumthang. Today Ura is best known for its annual Yak dance festival or Yakcho, an event that attracts tourists visiting the region.

From Thimphu the drive to Ura takes about fourteen hours and when you arrive you are essentially at the center of the country, evidence of Bhutan's small size. It is a long and winding drive that takes you up and down mountain passes. At times the route is slow and circuitous. The road joining Western Bhutan to the East is a considerable accomplishment considering that every mile was blasted out using dynamite and cleared by hand. The road can be perilous for both travelers and road workers. Bhutan's roads were built and are maintained by a large population of road workers. Their small makeshift settlements are found every few miles along the highway. Like the majority of labourers and construction workers in the country, road workers are largely from India, Bengal, or Nepal. Men, women, and children participate in roadwork. They break rock by hand using hammers and clear mud from frequent slides with shovels. Roads often collapse or wash out due to heavy rains, an occurrence common during monsoon season. It is the road workers who must clear the road by hand. As of yet, there are no safety standards for road workers and it is left to the UN to conduct needs assessments for those who live and work along Bhutan's roads.

The single lane road runs along what used to be ancient footpaths joining one isolated community to another. From time to time, you will see an old man walking the road carrying nothing but a small pack and walking stick who seems to be making an impossible journey. But, Bhutan is a pedestrian country and people have always walked great distances.

The further east you drive, the more you see that Bhutan is largely uninhabited. There are miles upon miles of thick green forest interspersed with waterfalls. It is evident not only in Ura but throughout Bhutan that water is one of the country's primary resources. In some places it bubbles up from the ground; in others it flows freely from the mountains. Hydroelectricity is

Bhutan's largest export. Periodically a troop of monkeys crosses the road, only to disappear again down the side of a mountain. The abundance and variety of plants, insects, and animals is astounding. At times, the whole appearance of the forest changes, each change indicating a different climatic and ecological zone. Cows roam freely along the roadside, most of the time unaccompanied.

Houses cling to mountainsides in small clusters or alone. Fields are terraced and angle steeply down the mountain, but are nonetheless green and fertile. Larger villages are marked by fortresses or Dzongs, which stand protectively and imposingly over the town. They are the remnants of a time before unification when the country was divided and ruled over by a number of petty kings and monk-rulers who fought one another for power. At one time, the Dzongs also protected people from invading armies from Tibet. Periodically my counterpart recited prayers where the road was particularly narrow or the fog particularly thick. Nearing Ura, there were times when the fog came up across the road obscuring everything but a foot or two in front of the car.

Ura is a small village located slightly east of the centre of the country in a valley of the same name. The district consists of six major villages with 229 households covering an area of about 267 square kilometers. Ura is currently the only village with hydroelectric power, which it received in 1987. Shingkar, a village about 45 minutes from Ura by car, receives its power from solar panels placed on the roof of each household; these were provided with assistance of the Indian government. During my stay in Ura, I traveled to Shingkar at the invitation of my host family and spent a day there, an experience that I will describe in more detail later.

The original inhabitants of Ura were nomadic people, a practice that continues today. In Ura I met members of a family who live a nomadic life. They make their way back to the family home in Ura about once a year. Supplies are packed into baskets, which they carry as they move from pasture to pasture with their cattle. While following the cattle they leave their children with family in Ura. The children go to school in Ura and are primarily cared for by their aunt.

Ura sits at a higher elevation than Thimphu, making the climate much harsher. Although it was summer when I visited, the weather conditions changed frequently. Strong winds bring clear hot days and foggy damp nights. The climate is such that they cannot grow rice. Although the temperature can be quite warm during they day, it drops considerably at night. Instead, they grow barley, buckwheat, and potato. Potatoes, like the solar panels in Shingkar, were introduced by a project sponsored by the Indian government. Before roads connected Ura to the rest of Bhutan, people walked miles over mountain passes to trade for rice. Although it was hot and dry in the summer, the residents reported that winter is bitterly cold. But the valley, with its rich grassland and plentiful water supply is ideally suited for cattle grazing.

Most of the valley in Ura is grassland, but the mountains are covered in thick pine forest. Stone or wood fences divide individual pastures. Walk through the village and you will find raised stone pathways, which take you past traditional houses and gardens. Woodpiles and willow trees hug the stone fences surrounding each yard. Follow these paths in any direction and they invariably take you to fields and pastures on the outskirts of the village, where prayer flags seem to sprout from the ground like blade of grass. The well-preserved houses and pathways are said to give Ura a medieval feel that is entirely unique (Ardussi 2004).

Covered in numerous varieties of grass, scrub and wildflowers, the valley floor is bisected by a steam that winds and twists through the cattle pasture like a snake. According to local belief, a Naga or sake spirit once plagued the community causing disease. A lama chased the snake away and as the spirit fled, it left its track on the valley floor, which is why the stream winds from side to side instead of straight.

The house where I stayed in Ura is a traditional Bhutanese house consisting of three stories. The first story is typically used for storage, although traditionally it was used to house cattle. For sanitary reasons, however, they are now kept in a paddock beside the house. The kitchen and main living quarters are on the second floor. The kitchen is a multipurpose room and is used for food preparation, cooking, and eating. It also functions as the social heart of the house where family gathers in the evening, sitting on the floor. The kitchen is where the stove is located and is the only source of heat in the house. The stove uses wood for fuel and sits low to the floor. The house has a third level where there are additional bedrooms; it is also where the family shrine room is located. A steep wooden ladder leads to the third floor. The interior of the house is constructed of huge wooden beams. Carefully cut pieces of stone form the exterior of the house, and like all Bhutanese houses, the roof sits above the third floor providing a space for drying and storing hay, vegetables, and meat.

There are no indoor bathing facilities but there is a 'bath house' a few meters from the house. It is a small shack made of wood and stone with a large aluminum tub. The bath water is heated in a metal drum over a wood fire and it can be mixed with cold water from a hose. This is a luxury that is enjoyed about once a week. Laundry is also done outside at a cold-water tap with a brush and soap and is hung to dry. Because of the dry air and the high winds, the clothes generally dry quickly.

Several family members live in the home on a temporary and permanent basis. The family consists of a grandmother 'Granny' or Aya in Dzongkha, her son and his family and two other female relatives. Granny is a devout Buddhist and spends many hours in her room reading texts and reciting prayers. Throughout the day, she carefully counts her prayer beads, gently fingering them one by one while uttering a mantra, "*om mani peme hung*". Reciting this mantra is said to invoke benevolent attention and blessings from Avalokiteshvara. Translations of this mantra are various and complex, however, it can be translated as "that which protects the mind" (Sogyal Rinpoche 1993, 71). Although in her eighties, Granny had recently gone on pilgrimage to a sacred Buddhist site, traveling long distances on foot. Other family members are not as demonstrative but also practice, offering prayers in the shrine room and counting prayer beads. Reincarnation is part of the family's social reality. The family reported that two of Granny's grandchildren are reincarnations and a third may also prove to be a reincarnation. Both children have exhibited certain behaviours, for instance a preference for certain objects that are not typical for children, as well as knowledge of people and places that have been attributed to remembering a past life.

Like many women of her generation, Granny has given birth to fifteen children, although only six survived. At that time, there was no BHU in Ura, so she had few options in terms of where to give birth. Today the BHU is equipped with a birthing room and women have access to biomedical and traditional services; both are provided at the BHU.

Life in Ura is relaxed yet insistent. The household is impressively self-sufficient. There is a certain rhythm to the day, moving forward with the passing of time, yet always in the moment. Restful periods are interrupted by the need for food, and tasks that must be completed to keep the farm running. Meal times dominate the day and serve as a way of marking the passing of time; there are no clocks in the house.

Chilies are part of every meal, despite the fact that they are not grown locally; crushed, chopped, or whole they are a part of every meal. Bumthang is well known for its dense buckwheat bread, recognizable by its dark green color. It is served uncooked with red chili paste and has the consistency of pizza dough. It can also be kept for days and hardens to a rock-like consistency. Everything is used and reused and nothing is wasted. What is eaten for dinner is generally eaten for breakfast the next day. Virtually all ingredients, except chilies and rice, come from household gardens or are bought locally from other farmers. For example, cheese is made from milk that is poured into a large pot and heated on the stove. The leftover liquid is served as a drink, which is particularly good when eating a dish with hot chilies. Milk is also made into butter that can be eaten with buckwheat bread or used in suja (butter tea).

Ara, a kind of liquor made from buckwheat is brewed at home on the stove. The household where I stayed was well known in Ura for its particularly potent ara. Ara is often the first thing that is offered to a guest when entering a home, even before tea. Cups are filled liberally and often. But even more than ara, doma is chewed and is as much a part of the rhythm of life as eating, maybe more so. Doma or betel nut is the fruit of a species of palm native to Asia and parts of Africa. It was introduced to Bhutan as early as 1774 as a result of the improved road system between India and Bhutan (RGB 2006). Commonly used throughout Bhutan, its wide spread use is evident from the red stained teeth and mouths of users; doma spit can be seen all over roads and sidewalks and is considered a public nuisance by the government. They would prefer to keep the streets clean for tourists. Typically, the nut is cut into small pieces and placed in a betel leaf coated with lime. Prepared packets of betel nut, leaf, and lime can be purchased on the side of the road or in shops. Most people buy large quantities because it is used quickly. Doma acts as a stimulant and is mildly intoxicating. It is the fourth most addictive substance in the world (Boucher and Mannan 2002). Most adult members of the family take doma after each meal. Granny is seldom without doma and chews it constantly. It is an essential part of social occasions and is brought out and offered to guests.

Food is not only cultivated in Ura, but is picked wild as well. Fiddleheads and mushrooms are commonly eaten in the Bumthang region. When driving to Eastern Bhutan, it is common to see local people selling fiddleheads, mushrooms, and vegetables at the side of the road. Rural Bhutanese rely on wild-crafted resources to make a living. Again, everything is processed by hand. There are no blenders in Ura, only mortar and pestle. Each day begins and ends the same way, up at 5 am and to bed by 9 or 10 pm. The television, which is conspicuously covered by a sheet during the day, is turned on at night and only then as background noise, or to entertain the children. Many hours are spent talking or just sitting in silence. But in Ura I found that time never feels wasted, even when one is inactive. Just being together seems to be a way of life.

Dawa Pelzang

Dawa is a monk by profession and was born and raised in Ura. He is 61 years old. Due to a sudden illness he now lives with his family in Ura, cared for by his younger brother and parents. His mother is 94 and his father is 95. Dawa's mother has 5 sons and 2 daughters; 2 of her sons are at home including Dawa and his younger brother. As I approach, he sits on a chair outside on a small deck that juts out from the second story of the house; he looks out over the deck of the house and does not make eye contact. Like all the houses in Ura, this one is made of wood and stone. There is a large set of wooden stairs leading up to the second floor where the family lives.

I am told that Dawa suffers from paralysis, which according to the family began as a tickling sensation. Through my counterpart, Dawa's brother describes how Dawa became ill. One day he was performing a puja and taking tea when an attack of some kind happened. As a result he was left paralyzed and lost the function of his limbs. The paralysis is not complete because Dawa is able to sit on his own. After the attack, the first thing the family did was to take Dawa to the Traditional Hospital in Thimphu. There he took steam treatments, gold and silver needle treatments, and acupuncture. But he had little improvement.

Dawa's family then took him to JDWNRH in Thimphu. Now, I am told, he takes allopathic medication for his condition, which his family reports, he finds helpful. The family shows me a plastic bag that contains Dawa's medications, and there are many. They also perform puja, believing that some spiritual assistance may prove effective. In order to discover the cause of Dawa's illness, the family requested the assistance of an astrologer. The astrologer suggested that it could be black magic; however when Dawa went again some time later, the astrologer said that the black magic was washed away. Now he believes that it is his karma that has caused his illness. According to his family, it could be that in a past life Dawa committed bad deeds or could not control his desires. Left unresolved, they have come back to afflict him.

The Bone-Setter

Kezang Dorji is a 78-year-old man and has lived in Ura his whole life. His household consists of seven people, including two daughters, their husbands and children. According to Kezang, there used to be 3-4 bone-setters in Ura, but today he is the only one still alive. He is a carpenter by trade and constructed many of the houses in Ura. He tells me that he was drawn to the practice of bone-setting at an early age. He is self-taught, learning the skill of bone setting through observation. He treats fractures and joint dislocations of all kinds, both complex and simple. After assessing the injury he applies a paste made of flour and water and then wraps the area with a cloth. He uses a variety of different treatments, including herbs and a heated mixture of flower, water, and salt, which he applies to the break. He tells me about his son as an example of a successful treatment. His youngest son fell and fractured a bone in his leg, was treated by his father and made a full recovery. He says he diagnoses an injury by feel and that he can tell whether a bone is broken or dislocated. He reports that generally, when the cast falls off, it is a sign that the break has healed. The worst case he ever treated was someone with a badly dislocated ankle, meaning all the bones in this person's ankle were broken. He treated this individual successfully. He tells me he has also treated a teacher at the local school, who was injured while playing soccer. The young man was brought to him, treated and healed in three days. He also treats animals with the same techniques.

When I asked him what sort of payment he accepts, he responded that clients bring him what they wish to offer in payment. He believes that he is providing a service to the community.

I also asked him about his own health and the told me that he lost his eyesight once but recovered it, and that he also suffers from chest and back pain. When he lost his eyesight he performed a puja and as a result recovered. Following the loss of his eyesight, which he describes as an "attack", he began taking medication prescribed by the Health Assistant at the local BHU. As a preventive health measure he also takes what my counterpart calls "holy water". It is special water from a spring in Ura know for its healing properties. He and his wife visit the spring regularly to bath in the water. The locals believe that the water cures illness and is also good for general health. They heat the water, which can be poured into a tub near the spring.

The Basic Health Unit

As part of my trip to Ura, my counterpart took me to visit the local BHU. In Ura, it is obvious that available health care services are more limited than those in Thimphu. Unlike Thimphu, there is no hospital and therefore no emergency services. Residents in Ura rely on the BHU for all of their immediate health care needs. The situation in Ura is illustrative of many villages in the country. However, Ura is better equipped than many other villages; like Thimphu, Ura has the benefit of a combined health service, including access to biomedical services and traditional medicine.

The BHU is located on the side of a hill not far from town. The mostly wooden structure is colorfully painted with black, white, and red paint. Community health posters have been placed on the outside walls of the building. One describes proper hand washing techniques and the other warns against signs and symptoms of bird flu; it is virtually impossible to buy chicken in Thimphu and often difficult to buy eggs as well. The building is small and consists of 3 to 4 rooms. There is no doctor, but the staff consists of a Basic Health Worker, a health assistant, a nurse, a Tibetan doctor, and a caretaker. The BHU was built in 2004. They see from 14-15 cases a day. The Basic Health Worker tells me that the most common condition treated at the BHU is hypertension. I asked why hypertension is so prevalent here, and he says that it is because Bhutanese generally eat a lot of salt and butter. I asked how he treats patients with this condition. He replied that patients are given blood pressure medication and diuretics and are also offered diet advice. The Basic Health Worker also tells me that one of their most important roles is administering vaccines to children in the community, which happens twice a year. This is also their busiest time of year. The unit has a ward with 4 beds, although the day I visited it was empty. According to the Basic Health Worker, people in Ura come to the BHU for traditional and biomedical treatment. For more serious cases patients are referred to the hospital in Jakar, which is a two to three hour drive depending on road conditions. Home visits are made by the staff to check sanitation and health status. This is a small example of what health services are like in rural areas.

Shingkar Village

Shingkar is also located in the Ura valley. From Ura it is about a forty-five minute drive on a bumpy road of stone and gravel. The road climbs high above Ura through pristine pine forests until it descends again into the small valley where Shingkar lies. Presently the village is at the end of a road connecting Shingkar to Ura. The government will begin work on a new highway through the valley, connecting Shingkar to Eastern and Western Bhutan. Locals speculate about what effect the new highway will have on life in villages like Ura and Shingkar. The new road will make it much easier for tourists to access tiny villages like Shingkar, bringing income into communities with small economies. But the road will inevitably bring many changes as well, many of which larger towns like Thimphu are now facing.

Currently, Shingkar is without hydroelectricity and relies on solar power. There is a panel on top of every roof, placed alongside prayer flags. The village is much smaller than Ura but similar in its layout. Houses are in the traditional style and are clustered together. Also like Ura, paths constructed of large pieces of cut stone connect the houses to one another. I was invited to visit Shingkar by my host family in Ura. They are related to a family in Shingkar and I spent the day in their home. Typical of Bhutanese hospitality, I was offered a full course meal, consisting of several dishes, including dal (a lentil dish), ema datsi (cheese and chilis), and several meat dishes. Meat is not easily obtained in Bhutan so when it is offered to guests, it is a sign of prosperity. In addition, I was offered many cups of ara followed by liberal amounts of suja (butter tea). Like the house in Ura, there are many relatives of different generations living in the same household. Fortuitously, while I in Shingkar I met a young man who proceeded to tell me in some detail about his own illness experience. My conversation with this individual is illustrative of how and when many Bhutanese choose to seek out and use multiple health care options. I have called him Rinzin.

Rinzin

Rinzin is a 33-year-old man, married with two small children. When I met him, he had just come back from Australia and had been home for about two weeks. Rinzin told me that had been in Australia for one year completing his Master's degree in education. What began as a general conversation about life in Bhutan, turned into an in-depth interview about his ongoing health problems. I asked him to describe his symptoms. He told me that his symptoms started roughly five months prior to returning to Bhutan from Australia. He reported to me that his symptoms included headaches, body pains, and "giddiness" or dizziness. He said he experienced what he described as pins and needles in his limbs. He also reported having trouble sleeping at night. Given all of these symptoms, which Rinzin told me he found quite disturbing, he decided to visit a biomedical doctor in Australia, in the hopes that he could get a diagnosis and some treatment. The doctor sent him for testing, which included blood tests, a CT scan for his headaches, and X-rays. All of the tests came back negative, and he told me, given that it appeared to the doctor as though there was nothing wrong, he referred Rinzin to counselling. He was also given painkillers for the headaches; however, according to the Rinzin the headaches did not stop. When he went to see the counsellor, she suggested that he could be suffering from stress and anxiety as a result of feeling homesick. I asked Rinzin whether he found therapy helpful, and he replied that he did find it useful. The counsellor gave him a relaxation CD, which he finds helps his insomnia. But overall, he told me, his symptoms did not improve.

Upon returning home from Australia, Rinzin still experiences all the symptoms he had while there. Because they have not diminished, he sought the help of a lama. The lama gave him medicine, which Rinzin said controls his symptoms. The lama also advised him to perform a puja. He told me that he chose this route because all the physical tests came back negative, and that he now believed that there was a spiritual cause for his sickness. He further told me that he believed that the cause of his illness could be some kind of curse, meaning that someone was performing and directing mantras against him. Rinzin reported that the lama told him that he would get better but that it would take some time. The day I visited Rinzin, he was holding a puja. Rinzin had enlisted the services of a group of local monks.

Near the end of our interview I could hear drumming coming from inside the house. I asked Rinzin if I could observe the ceremony. Rinzin took me upstairs where the monks were performing the ritual and told me that the puja is performed over three consecutive days. Approximately fifteen monks stay at the house. As part of the ritual they make a special cake called a tordho, which literally means, “make cake and burn cake”. Tordho is also the name given to this type of puja. The tordho is a structure made of dough and paper; essentially it looks like a pyramid made of flags. The colorful flags are adorned with pictures of protective deities. The monks chant mantras, directing them at the tordho, which Rinzin also described as a type of shield. Rinzin further told me the mantras are performed to counteract the spell that has been directed against him. He was careful to clarify that the mantras performed on his behalf were not for retaliation but rather to remove the negative spell from his own person. Rinzin described how the puja would culminate with the burning of the tordho, effectively nullifying the spell. The puja included chanting, drumming, the blowing of large long horns, and burning incense; it was an impressive performance. Like many aspects of Bhutanese culture, puja are a full sensory experience, with a tangible aesthetic quality.

The monks only stop the ritual for tea breaks, lunch, and dinner. Everything is provided and paid for by the family, including meals; however there is an attendant, whose sole job is to tend to the monks while they are staying in the house. Where payment is concerned, essentially it is up to the client to decide what he or she thinks is appropriate, although generally speaking, the more a person pays the better off they will be in long term. Giving money or tribute to a monastery or to one's personal lama accrues merit, and contributes to the effectiveness of the 'cure', so to speak. Rinzin stated that he was paying about 30,000 Nu for three days, which is about $780.00 Canadian dollars. Thus, puja can be an expensive aspect of health care in Bhutan, involving a considerable investment, a fact that I have heard from many Bhutanese.

Rinzin's use of a variety of health care options is illustrative of medical pluralism in Bhutan. Tibetan Buddhists like Rinzin typically use multiple health care options for an illness episode. Flexibility, pragmatism, and the availability of options characterize how people choose to use medical frameworks like biomedicine, Tibetan medicine, and Tantric healing. From an emic perspective, when seeking relief from symptoms and suffering individuals do not experience conflict when moving between systems but approach them as equally viable, complementary healing modalities.

Chapter 5

CONCLUSIONS AND FUTURE RESEARCH

I encountered several challenges that limited the breadth and depth of this research. Due to some government restrictions and mixed messages from various people with whom I was working as to what I could and could not document, I approached this research carefully. As a result, most of my data was collected through participant observation, and I conducted few structured interviews. Thus, more in-depth formal interviews with a larger number of people would contribute a great deal to any future research on the health care system. One of the biggest challenges for this research was that I did not have enough time. Because I could not stay in the country beyond a period of four months, I was not able to follow-up on connections that could have been useful to me; unfortunately, it was a few weeks before I was to leave that I began cultivating connections that I believe would have proved valuable.

To follow-up on the research presented in this thesis, there are several areas that would benefit from additional fieldwork. Were I to return to Bhutan, I would continue to examine each of the three areas I began to document: Tibetan medicine, biomedicine, and Tantric healing. I am left with many questions as a result of this preliminary study, in particular, questions as to the nature of and relationship between these three areas of the medical system. But even beyond Tibetan medicine, biomedicine, and Tantric healing, Bhutan has an abundance of health care practitioners, and to broaden the examination of pluralism I would look at other health care traditions and healers in the country, including homeopaths, shamans, and various other folk practitioners. Homeopathy is an intriguing area because it appears to be a newly emerging health care option, imported from India, which is gaining in popularity. Moreover, a language study is essential for any future research on health and healing in Bhutan. It would contribute to a better understanding of concepts of health from an emic perspective and also ease some of the awkwardness and inaccuracies associated with using linguistic categories like spiritual, sacred, secular, religion, and medicine.

There remain significant gaps in my ethnography of health care in Bhutan. They pertain to all areas of this thesis, but many key questions relate to how rapid culture change will affect health care in that country. For example, Bhutan is holding its first election this year (2008). Given the lack of distinction between political, social, religious, and medical spheres of experience, the democratic process may have a significant, if undetermined, impact on health care in the country. Life in general is changing so rapidly in Bhutan and I believe, given the dearth of ethnographic research on the country in general, it is important to document as much as possible. Some key questions include: How frequently and by whom are Tantric practitioners used as primary health care givers? Does any particular segment of the population use Tantric practitioners for primary health care, for instance older, rural, or more traditional Bhutanese? How has the role of Tantric practitioners changed since the introduction of biomedicine to the country? What role does cost play in selecting the services of a Tantric healer or lama, especially considering that Tibetan medicine and biomedicine can be accessed free of charge? Has biomedical theory, technology, and ideology changed the relationship between Tantric healers and their clients? Is there a growing mistrust of lamas and their methods by segments of the population, and is this reflective of a larger socio-economic divide between upper and lower-class Bhutanese; or is it reflective of a biomedical culture that is growing in professional dominance, asserting itself over other health care systems? What factors may be contributing, to what I perceived, as an emerging gap between Bhutanese of higher and lower socio-economic status? On a practical level, will the large-scale manufacturing of Tibetan medicine lead to a shortage of raw materials for local people? To what extent has the institutionalization of Tibetan medicine changed the practice as a whole? Within the larger context of the study of Tibetan medicine, precisely how and to what degree is Tibetan medicine in Bhutan different from that practiced by its community of origin? This question in particular suggests new directions for inquiry into how anthropologists define pluralism. Gathering more data on different versions of Tibetan medicine in Bhutan, and in other Tibetan communities, would be one way to follow up on the research in this thesis with the broader view of redefining pluralism within medical systems that are pluralistic. Medical systems in Bhutan also demonstrate a high degree of permeability even between systems, like the biomedical system and the Tibetan system, which have been traditionally thought of as unrelated and self-contained. Further research on how medical systems in Bhutan are interconnected may lead to new conclusions about how we define and demarcate medical systems in general. I hope these and other question are studied in more depth in the future.

The purpose of this research was twofold: the first, to complete a preliminary ethnographic exploration of health care in Bhutan, a topic virtually unexplored in this country; and the second to produce an ethnography documenting one of the least known countries in the world. I have demonstrated that Bhutan has a unique and colourful Buddhist culture and a development policy that reflects this culture. Gross National Happiness is an approach to development that seeks to create the conditions under which happiness can be pursued. As I have attempted to show, rather than remaining static and unchanging, the government has embraced change. Change and modernization are occurring at a rapid pace. On a return trip to the country, seven years after her departure in 1998, Jaime Zeppa remarks on the "transformation" (2006) that had occurred. Therefore in a few short years, what is presented in this thesis may not reflect Bhutanese realities.

In this thesis I have attempted to show that Bhutan has a medical system based on pluralism. Pluralism characterizes many aspects of culture in Bhutanese society, most prominently Buddhism. As an extension of that culture, the health care system is also pluralistic. Following ethnographers like Arthur Kleinman (1981) and Margaret Lock (1980), I have taken a highly contextual approach to the documentation of health care options in Bhutan. As Lock suggests, "any attempt to analyze a complete medical system must include not only a description of the social structure, the social organization, and the belief system, but must also demonstrate how this relates, both historically and currently, to the total cultural context" (1980, 11). With this in mind, I began in Chapter 1 by introducing several aspects of culture in the country that exhibit pluralism. Historically, Bhutan has been a highly decentralized state, owing in great part to its mountainous terrain, a geographical reality which isolated communities, largely precluding the development, until recently, of a national culture. Thus communities developed highly localized cultures, including legal, economic, and political procedures and structures, in a plurality, so to speak, of "local environments" (Kleinman 1981, 39). I discussed the limitations of language when attempting to write about a culture, where from an emic perspective, conceptual categories like religion and medicine, spiritual/sacred and secular inadequately describe the interconnected nature of many elements of experience. Conceptually speaking, in Bhutan, Buddhism and medicine are one and the same. Health and wellness come as a result of practicing the Dharma. Despite the inadequacy of these linguistic categories, I concluded that it is difficult to eschew them. Until we have a new language to describe the fullness of experience, these categories can only be used to approximate social realities in other cultures. I have tried to use them sparingly and where appropriate; in some instances Bhutanese who I interviewed in English also used words like "spiritual" and "religious" to describe different aspects of health care.

In Chapter 2, in line with a contextual approach, I described Bhutan's historical background. I brought attention to the image of Bhutan as an exotic timeless place, which is untouched by the realities of the modern world. The exoticized version of the country exists in sharp contrast to the rapidity with which culture change has taken place in a few short decades. The country has responded quickly to regional geopolitical pressures by creating a new national culture and identity, capitalizing on aspects of Buddhist culture like happiness and promoting it to the West. In a sense, Bhutan has become the romanticized version of itself to enlist the help of other bigger nations to protect its sovereignty and culture.

Bhutan's political history is virtually inseparable from the history of Buddhism in that country, and therefore can be divided into periods that are pre and post-Buddhist. For Tibetan Buddhists, this philosophical tradition is the backdrop for most spheres of experience, and as I have attempted to show, is tightly bound to concepts of health and to methods of healing. Thus I continued in Chapter 2 by outlining the history of Buddhism, the philosophical context of health care in that country. The Buddhist concept of karma is highly relevant to an individual's current state of health and also to potential states of health in future lives. As the law of cause and affect, karma dictates health and well-being. Equally as important are the many spirits and deities who inhabit the Buddhist sacred universe. One of the elements of culture and medicine I have attempted to show throughout this thesis is the quality of balance. Maintaining a balanced relationship with spirits and deities, balancing negative karma with merit, and bringing balance to the energies and desires of the mind, and therefore the body, highlights the importance of balance in Tibetan Buddhism.

Chapter 3 introduces medical pluralism in Bhutan by looking at the method of health care delivery the country has chosen. The government has adopted primary health care as the model that will bring medical services to the least reachable in the country. The primary health care model values health for all and also encourages the development of community-based initiatives. In Bhutan, primary health care is a plural system, which incorporates biomedicine and traditional health care in one integrated system. Efforts to further integrate the two systems are ongoing.

In my ethnography of health care in Bhutan I surveyed Tibetan medicine, biomedicine, and Tantric healing. Tibetan medicine is a system with a complex etiology of health. It is inseparable from Buddhism, the philosophical tradition from which it emerged. Physiology, causation, diagnoses, and treatment are contained in a substantial set of medical texts called the Four Tantras. Because of the complexity of this distinct medical tradition, I began with a general overview of Tibetan medicine, its history and connection to Buddhism. The origins of Tibetan medicine are found in Tibet, and Bhutan shares a common philosophical, political, social, and medical history with that society. I have pointed out throughout this thesis the elements of culture and history that Bhutan shares with other Tibetan Buddhist societies, to demonstrate a common heritage but also to underscore the country's uniqueness. Bhutan is the last remaining independent Buddhist Kingdom, which includes a medical tradition that has not been altered by colonization.

I briefly outlined Tibetan medical theory, although this description is by no means exhaustive. I then describe Tibetan medicine in the specific context of Bhutan. Although Tibetan medicine in Bhutan shares a common heritage with Tibetan medicine in Tibet, I would suggest that Tibetan medicine in Bhutan is itself another version of the Tibetan medical tradition. Following its introduction to the country, Tibetan medicine was adapted to the unique local culture and environment. I would suggest based on this research that Tibetan medicine is itself pluralistic. Lynn Payer (1988), for example, documents pluralism within the biomedical system, a system that has been characterized by many anthropologists as a discrete medical system when compared with other medical systems. In Bhutan there appear to be several versions of Tibetan medicine. Certainly, at the institutional level the practice of Tibetan medicine has been changed by large scale mechanized production of Tibetan pharmaceuticals. What was once part of a Tibetan physician's set of skills, has been isolated from the practice as a whole. At the institutional level, doctors no longer make their own medicines. I demonstrate, however, that there are Tibetan doctors currently working outside the jurisdiction of the Ministry of Health who still harvest, process, and compound their own pharmaceuticals. There are also Tibetan physicians working inside the monastic system, which may represent another localized version of Tibetan medicine.

Chapter 3 also documents the role of lamas and other Tantric practitioners in the health care system. It has still to be determined whether Tantric healers represent a variant of Tibetan medicine or a distinct medical system. Some Bhutanese use these practitioners for primary health care and some do not. But they are commonly enlisted to determine the cause of an illness and to recommend a course of treatment, even when the protocol in question is biomedical. Finally, I elucidate some points of contention between lamas and the biomedical community, which are illustrative of a clash of medical traditions.

The next section in chapter 3 documents biomedical health care in a very specific context, JDWNRH in Thimphu. I document aspects of the "indigenization" (Kleinman 1980, 55) of biomedicine. Biomedicine is a relatively new arrival to the country when you consider Bhutan's ancient history, and has been adapted to the Bhutanese context quickly. Several aspects of Tibetan medicine have permeated biomedical diagnostic method, treatment, patient care, and also the surroundings in which biomedical health care takes place. Most striking are examples of patient expectations with regard to biomedical diagnostic procedures. A biomedical physician reported that patients expect to have long interviews and have their pulse taken, important components of the Tibetan diagnostic method. If the doctor does not use these techniques, patients leave dissatisfied with their physician and with the biomedical experience in general. Another example of the indigenization process is the incorporation of family members into the treatment and recovery of patients. Biomedicine has not pushed out traditional medical beliefs but has, in fact, been changed by them, just as the introduction of biomedicine has altered aspects of traditional Tibetan medicine. Bhutanese, then, have a plurality of highly permeable medical options from which to choose. Moreover, what were previously conceived of as distinct and mutually exclusive medical systems are much more interconnected and perhaps interdependent than once thought. This hypothesis is not only relevant to the study of Bhutan's health care system, but to the study of health care systems in general.

In the final two sections of chapter 3, I expand upon the conclusion that Bhutan is a pluralistic society, and that Bhutanese use a variety of treatments in a complementary way. I document a Bhutanese term 'menchoy rimdo'. Menchoy rimdo attests to the side-by-side nature of medical treatment in Bhutan. Religious rites and the treatment of symptoms for an illness should always go hand-in-hand. Addressing the root cause, which is usually karmic in nature, and the resulting illness is a pluralistic approach to healing. Lamas are called upon to address the spiritual cause of the illness, but treatment of symptoms can employ Tibetan medicine, biomedicine, or both.

To further illustrate how menchoy rimdo expresses itself in the lives of Bhutanese people, I take a micro-social view of pluralism by documenting the use of multiple health care options by a family living in Thimphu. The family uses lamas, Tibetan medicine, biomedicine, homeopathy, and home remedies when treating illness. For the family, there is no conflict between these different options, but rather choices that are used when the situation calls for it. They are representative of many Bhutanese families in Thimphu; the children have been educated abroad, they are upper-class, and live in an urban area with unrestricted access to the best health care services in the country. They have disposable income and are able to travel outside Bhutan for private health care. While Bhutan has traditionally been a highly stratified society, emerging from a feudal system in the 1950s, class may come to play a larger role in the country as the new educated elite has access to greater amounts of wealth and economic prosperity. The health care system will also reflect these changes as the government plans to introduce user fees for those who can afford to pay for health care.

Finally, Chapter 4 presents research that is part ethnography of rural Bhutan, and a continuation of my examination of medical pluralism. I describe two villages in rural Bhutan, Ura and Shingkar, where I conducted fieldwork. Although I was there for a very short time, I found the data from these two rural communities very rich. I began with a description of the journey to Ura and the setting. I then outlined aspects of the data that add to or complement that which I had already described. Dawa Pelzang illustrates the role of karma as the cause of a sudden and life altering illness. The village bone-setter in Ura is an example of a local health care practitioner, specializing in breaks and sprains. He is self taught and has practiced in the community successfully for decades. I then describe and outline the role of the BHU in Ura. Health care at the BHU is pluralistic, offering biomedical and Tibetan treatment. This is one of twenty other district hospitals and BHUs that are equipped to provide both types of health care to patients.

I complete Chapter 4 with a narrative of an interview I conducted by chance with a young man in Shingkar. I describe his illness experience and his search for an appropriate treatment, which began with biomedicine and psychological therapy and ends with a puja, performed over three days. I was fortunate to observe and document part of this puja; it contributed immeasurably to my understanding of this type of ritual and to the place it occupies in this pluralistic health care system.

The conclusions in this thesis echo findings by others who have completed similar research projects. Medical pluralism is the norm in most, if not all, parts of the world. But this thesis alludes to medical systems that are much more permeable and interconnected than previously thought. In Bhutan, a medical system is not a discrete self-contained entity but an amalgam of elements adapted from contact with other health care systems. Biomedicine does not displace other medical systems but rather is adapted to the cultural context, in this case one where there is no distinction between spheres of experience like religion and medicine. Tibetan Buddhism teaches methods whereby practitioners can understand the true nature of all phenomena, which simply put, is that nothing exists in isolation; everything is interdependent and interconnected. From a Buddhist perspective, this is the true nature of reality. As an extension of Buddhist culture, medical systems in Bhutan demonstrate a high level of interconnectedness. As others (Callaghan 2006) who have produced ethnographies on the Himalaya have remarked, the absence of such distinctions between social, religious and medical acts makes the study of health care systems in this region particularly challenging (Callaghan 2006, 64).

Bhutan is a country that is changing rapidly. But rather than become a victim of modernization, the country is actively grappling with the tensions that come with increased development. By creating a development policy it calls Gross National Happiness, the country is attempting to preserve traditional Buddhist culture while also embracing many elements of modernization. Thus Bhutanese obey the law by wearing traditional dress while also carrying cell phones. Bhutan will not succumb to modernization but will continue to adapt just as other cultures do when faced with change. Buddhism teaches that change is inevitable and that it is the rejection of impermanence as an aspect of reality that causes suffering. It is likely that the country will hold to aspects of Bhutanese culture that have served it so well in the past: flexibility, pragmatism, and balance.

LIST OF ABBREVIATIONS

BHU	Basic Health Unit
CBS	Centre for Bhutan Studies
DANIDA	Danish International Development Agency
GNH	Gross National Happiness
ITMS	Institute of Traditional Medicine Services
JICA	Japan International Cooperation Agency
JDWNRH	Jigme Dorji Wangchuck National Referral Hospital
MoH	Ministry of Health
NITM	National Institute of Traditional Medicine
NTMH	National Traditional Medicine Hospital
OPD	Out Patient Department
ORC	Out Reach Clinic
PHC	Primary Health Care
RGB	Royal Government of Bhutan
VHW	Village Health Worker
WHO	World Health Organization

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